Board of Directors Meeting (PUBLIC)

Wed 06 October 2021, 13:30 - 15:30

Via Microsoft Teams

Agenda

13:30 - 13:30
0 min

1. Welcome and apologies for absence

Ken Jarrold, Chairman

13:30 - 13:30
0 min

2. Declarations of interest

Ken Jarrold, Chairman

13:30 - 13:30
0 min

3. Service user / carer / staff story

13:30 - 13:30
0 min

4. Minutes of the meeting held 6 October 2021

Ken Jarrold, Chairman

4. Board Public mins 01.09.21.pdf (9 pages)

13:30 - 13:30
0 min

5. Action log and matters arising from previous meeting

Ken Jarrold, Chairman

5 BoD Action Log PUBLIC as at 06.10.21.pdf (2 pages)

13:30 - 13:30
0 min

6. Chairman's Report

Ken Jarrold, Chairman

13:30 - 13:30
0 min

7. Chief Executive's Report

verbal update *John Lawlor, Chief Executive*

Quality, Clinical and Patient Issues

13:30 - 13:30
0 min

8. COVID-19 Response Update

Gary O'Hare, Chief Nurse

8. COVID update Board Report - Oct 2021 final.pdf (6 pages)

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13:30 - 13:30
0 min

9. Commissioning and Quality Assurance Report (Month 5)

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

9. Monthly Commissioning Quality Assurance Report - Month 5.pdf (12 pages)

13:30 - 13:30
0 min

10. Safeguarding Annual Report 2020/21

Rajesh Nadkarni, Medical Director

10. Safeguarding Annual Report 20_21_FINAL.pdf (16 pages)

13:30 - 13:30
0 min

11. Safer Care Annual Report 2020/21

Rajesh Nadkarni, Medical Director

11. Safer Care Annual Report July 20_21_FINAL.pdf (16 pages)
11.1 Appendix 1.pdf (25 pages)
11.1 Appendix 2.pdf (16 pages)

13:30 - 13:30
0 min

12. Annual Deanery Quality Meeting Report

Rajesh Nadkarni, Medical Director

12. Board report HEE Quality 2021.pdf (8 pages)

Workforce Issues

13:30 - 13:30
0 min

13. Workforce updates (Equality, Diversity - Health and Well-Being)

Presentation *Lynne Shaw, Executive Director of Workforce and Organisational Development*

13:30 - 13:30
0 min

14. Annual Report for Medical Appraisal / Revalidation 2020-21

Eilish Gilvarry, Deputy Medical Director

14. Annual Board Report 2020-21 final version.pdf (15 pages)

Strategy and Partnerships

13:30 - 13:30
0 min

15. Integrated Care System (ICS) Developments

verbal update *John Lawlor, Chief Executive*

Regulatory Items

13:30 - 13:30
0 min

16. Emergency Preparedness, Resilience and Response Annual Report 2020/21

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Gary O'Hare, Chief Nurse

16. EPRR Annual Report - Board of Directors Final Sep 21.pdf (6 pages)

Board Sub-Committee minutes and Governor issues for information

13:30 - 13:30
0 min

17. Quality and Performance Committee

Alexis Cleveland, Chair

13:30 - 13:30
0 min

18. Audit Committee

David Arthur, Chair

13:30 - 13:30
0 min

19. Resource Business and Assurance Committee

Peter Studd, Chair

13:30 - 13:30
0 min

20. Mental Health Legislation Committee

Michael Robinson, Chair

13:30 - 13:30
0 min

21. Provider Collaborative Committee

Michael Robinson, Chair

13:30 - 13:30
0 min

22. CEDAR Programme Board

Peter Studd, Chair

13:30 - 13:30
0 min

23. Charitable Funds Committee

Paula Breen, Chair

13:30 - 13:30
0 min

24. Council of Governor issues

Ken Jarrold, Chairman

13:30 - 13:30
0 min

25. Any Other Business

Ken Jarrold, Chairman

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13:30 - 13:30
0 min

26. Questions from the public

Ken Jarrold, Chairman

13:30 - 13:30
0 min

27. Date and time of next meeting - 3 November 2021, 1.30pm - 3.30pm via MS Teams

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Minutes of the Board of Directors meeting held in Public
Held on 1 September 2021 1.30pm – 3.30pm
Via Microsoft Teams

Present:
Ken Jarrold, Chairman
David Arthur, Non-Executive Director
Darren Best, Non-Executive Director
Alexis Cleveland, Non-Executive Director
Michael Robinson, Non-Executive Director
Peter Studd, Non-Executive Director

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

In attendance:
Margaret Adams, Public Governor for South Tyneside / Deputy Lead Governor
Beth Allan, Patient and Carer Involvement Lead *(for item 3)*
Allan Brownrigg, Staff Governor – Clinical
Fiona Grant, Service User Governor for Adult Services / Lead Governor
Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary
Denise Porter, Voluntary and Community Services Governor
Tom Rebair, Service User Governor for Adult Services
Fiona Regan, Carer Governor for Learning Disabilities and Autism
Paul Richardson, Appointed Governor for North Tyneside Council
Chris Rowlands, Equality, Diversity and Inclusion Lead *(for item 16)*
Becky Vicary, Service User *(for item 3)*

1. Welcome, apologies for absence and Declarations of Interest
Ken Jarrold welcomed everyone to the meeting. Apologies for absence were received from John Lawlor, Chief Executive and Paula Breen, Non-Executive Director

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

3. Service User/Carer Story
Ken Jarrold extended a warm welcome and thanks to Becky Vicary who attended the Board to share her story.

4. Minutes of the meeting held 4 August 2021
The minutes of the meeting held on 4 August 2021 were considered.

Approved:
- **The minutes of the meeting held 4 August 2021 were approved as an accurate record.**

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

There were no outstanding actions to note.

5.1 Out of area placements briefing

Following the August Board meeting, Lisa Quinn referred to the document which provided clarity for Board members and Governors regarding the definition of an out of area placement.

6. Chairman's Remarks

Ken Jarrold discussed the very challenging time for the Trust making reference to workforce challenges resulting in operational pressures and increases in demand for services. Ken acknowledged the significant impact of this on all frontline colleagues as well as the people we serve.

Ken also emphasised that despite the current pressures, the Trust continues to demonstrate good practice and performance referencing the shortlisted categories for the national HSJ awards. The excellent care, treatment and support the workforce provides locally will also be shared as part of the Annual Staff Excellence Awards scheduled to take place in a face-to-face ceremony on 3rd September.

Ken summarised by recognising that while not in any way minimising the challenges and pressures faced currently, the Board of Directors understand the challenges being faced and will continue to support colleagues moving forward.

Resolved:

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

7. Chief Executive's Report

James Duncan referred to the announcement of the HSJ awards shortlist and noted that the majority of nominations were underpinned by partnership working as part of a system and demonstrated the integrated approach to care and treatment in the North East and North Cumbria (NENC) in this regard.

James referred to the recent publication of national guidance in relation to the development of Integrated Care Systems (ICS) prior to ICS bodies formalising their role in April 2022.

As the Board is aware, the Trust's CEDAR programme was chosen as one of the 40 New Hospital Schemes as part of the wider national Health Infrastructure Plan. A call has gone out for Expressions of Interest for the next eight schemes to be considered as part of this programme. James noted that the demand against these would be significant. The Trust will submit the North Cumbria scheme to be considered as part of this process.

James referred to the report produced by NHS Confederation Mental Health Network highlighting the significant increases in demand for mental health support for children and young people across all services. The report notes the increasing concern that the mental health system for children and young people in England is reaching tipping point, with the pandemic having exacerbated existing challenges, including mental health inequalities. The report considers the impact the pandemic has had on children and young people's mental

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health, the services that support them, and how local systems are working in new ways to confront the issues before them.

James referred to a report produced by the Nuffield Trust which considers the NHS clinical support workforce, frontline staff who, while typically not registered professionals, deliver most of the hands-on care.

Michael Robinson referred to the Care Pathway Enhancement Clinics (CaPE) update and asked about the role of these in terms of Integrated Care Pathways (ICP). Rajesh Nadkarni advised that the clinics would commence as a pilot before being rolled out further and highlighted that there was significant interest in taking part from Primary Care services.

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 Trust's response to the pandemic noting that the position remained unpredictable at a national level. The Trust currently reported six COVID-positive patients. 24 members of staff had tested positive at the time of reporting and staff members continued to use Lateral Flow Device (LFD) self-testing kits as a key tool for early detection. Six outbreaks were currently being managed across the Trust.

Staff absence continued to increase, and Gary advised that work related stress and anxiety remained a key theme in staff sickness and referred to the Trust's offer in relation to health and wellbeing support for staff. This offer was under continual review in terms of exploring ways to support colleagues further.

Gary provided reassurance regarding the decision to proceed with a face-to-face staff award ceremony and advised that additional measures would be put in place to maintain safety, over and above those provided at the external venue including access to the ceremony only by those who have received both COVID-19 vaccinations and evidence of a negative LFD result within 24 hours prior to the event.

Finally, Gary noted that conflicting guidance had been received from national bodies in relation to the management of close contacts for people working in health and care organisations and that the Trust's current measures would be maintained until further guidance was received.

Resolved:

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

9. Commissioning and Quality Assurance update (Month 4)

Lisa Quinn provided an update on the position as at Month 4 and referred to the graph showing CNTW sickness over the last four years stating that the level of sickness combined with vacancy levels and annual leave was resulting in a significant risk to the Trust in terms of operational areas.

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Lisa advised that four Mental Health Act Reviewer visits had been undertaken during July and noted that the issues raised following the visit to Castleside were being addressed within the Group.

The Board noted a slight improvement in waiting times for adults and older people's services but noted a further increase in waiting times for children and young people's services particular within Newcastle/Gateshead. The Central Locality Group were exploring this further including the impact of neuro-developmental pathways and the need for additional support in relation to ADHD services across the footprint.

Lisa reminded Board members that a risk to maintaining the strong position in relation to out of area placements had been previously notified to the Board. On that basis, the report identified six out of area placements during July. Lisa recognised the hard work of the teams in continuing to maintain a strong position, and it was recognised that an increase in out of area placements had occurred because of bed pressures during July.

Lisa noted that in response to the pandemic, the Trust continued to operate in Operational Pressure Escalation Level (OPEL) level 2 in line with the national framework and as a consequence, the Trust continued to report to the Board on quality standards and therefore were not performance monitoring standards at the current time.

In terms of the financial position, James Duncan advised that the Trust remained on track with the financial plan for the first half of the financial year (also referred to as H1). James reiterated that that position remained dependent on additional system funding being received for the remainder of the year. At this stage, funding arrangements and financial planning for the second half of the financial year (also known as H2) was yet unknown which posed a significant risk in terms of financial performance and planning for the 2022/23 financial year.

Ken Jarrold stated that the position in relation to financial planning in the NHS was unprecedented in terms of the lack of national guidance and clarity and commended the teams for their ongoing work given the current uncertainty around planning.

Resolved:

- **The Board received the Month 4 Commissioning and Quality Assurance update**

10. Annual Flu Plan Report

Gary O'Hare presented the Annual Flu Plan which incorporated the impact of the pandemic. The plan currently focused on delivery of the COVID-19 booster as well as Flu vaccine although formal guidance was yet to be received in terms of the feasibility of delivering both vaccines at the same time. Until guidance is received, the Trust will continue to plan for the delivery of Flu Vaccinations.

Gary advised that it was envisaged that the Flu Vaccination Programme would commence week commencing 27th September with a mixed-model approach of ward based, community based and central based delivery of vaccinations.

The underpinning Communications Plan will again be fundamental in the delivery of the plan to vaccinate as many people as possible as early as possible.

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Resolved:

- **The Board received the Annual Flu Plan Report**

Strategy and Partnerships

11. CNTW Workforce Strategy

Lynne Shaw referred to the Trust's Workforce Strategy. It was noted that the Strategy was last refreshed in 2017. Considering the Trust's decision to refresh the overarching Trust wide strategy during 2021, Lynne asked that the Board approve a rollover of the current Workforce Strategy with a view to undertaking a review in 2022 to align with the overarching Trust Strategy refresh.

Alexis Cleveland reflected on the current challenges discussed earlier in the meeting about workforce pressures and emphasised the importance of progressing with current action plans and programmes of work, despite the deferral of the overall Workforce Strategy review.

Approved:

- **The Board approved the roll-over of the Trust's Workforce Strategy**

12. CNTW Annual Plan – Quarter 1 Update

James Duncan presented the report which provided an update on progress against the Trust Annual Plan for 2021/22. Despite the impact of the pandemic, James advised that significant progress was being made and noted several areas where performance monitoring metrics and indicators were still under development.

Ramona Duguid referred to appendix 2 which provided detail of the work undertaken to date. Ramona made reference to priority 3 which focused on service delivery and demand and advised that access and waiting times would be a key priority area for the Trust.

Ken Jarrold commended the work undertaken and the priority diagram which was clear and easy to understand.

Resolved:

- **The Board received the Quarter 1 Annual Plan Update**

Workforce Issues

13. Workforce Report – Quarter 1

Lynne Shaw presented the report and noted the changes to the national staff survey which has been amended to align to the NHS People Promise. The Trust has also reverted to a mixed model of online and paper copies of the survey to increase participation, particularly for front line clinical staff and those staff who do not have regular access to a computer.

Following a query from Peter Studd, Lynne provided an overview of the 'BIG conversation' which was held with members of the Trust's Improvement Collaborative to look at the staff survey results from 2020 and discuss the priorities moving forward. The process also included a second discussion with triumvirate Directors and Corporate leads to ensure that priorities were aligned.

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Peter Studd noted the placement of 25 registered nurse degree apprentices and queried the low number of placements given the context of the increased demand for resources currently. Gary O'Hare advised that the number of placements was dependent on factors including the number of apprentices the Trust can accept as a cohort from the University, the differences in criteria for different types of apprenticeships, and the Trust's approach to values-based recruitment.

David Arthur also queried size and scale in ensuring we have the right capacity of people coming into the organisation, taking into consideration the Trust's geography and areas of deprivation. Gary referred to the newly established Recruitment and Retention Group which was underpinned by four workstreams. Part of this work will look at the Trust's links with universities over the longer term but acknowledged a key challenge for the next 2 – 3 years will be the disconnect between inpatient services and community services as well as the investment required to support community services over the next 5 years.

Rajesh Nadkarni also emphasised the importance of improving access to areas of our local communities particularly our hard-to-reach communities. From an ICS perspective, Rajesh and Lynne were leading the Mental Health Workforce workstream which includes representatives from Health Education England and third sector partners.

Gary advised Board members that further detail of the work of the Recruitment and Retention Group would be provided at the Council of Governors session to be held on 15th September and a deep dive into workforce challenges was scheduled to take place at the Quality and Performance Committee.

Michael Robinson suggested that themes from exit interviews be included in future reports.

Resolved:

- **The Board received the Quarter 1 Workforce Report**

Action:

- **Themes from exit interviews to be included in future reports**

14. Guardian of Safe Working Report – Quarter 1

Rajesh Nadkarni presented the report which was taken as read.

Resolved:

- **The Board received the Quarter 1 Guardian of Safe Working Report**

15. Clinical Excellence Awards Report (CEA)

Rajesh Nadkarni presented the report and advised that the 2020/21 Local CEA round had been halted as a result of the pandemic, with the award money due to be distributed equally among eligible Consultants. On that basis, existing funding, including any money rolled over from the last two years, would be redistributed equally among eligible Consultants for the 2020 award round as a one-off, non-consolidated, non-pensionable payment in place of normal Local CEA rounds.

Approved:

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- **The Board received the Clinical Excellence Awards Report and approved the report for publication on the Trust's website**

16. Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Disparity Ratios Update

Lynne Shaw and Chris Rowlands presented the report and recommendations which would be aligned to the current Equality, Diversity and Inclusion action plan. Lynne noted that the report also included the Race Disparity ratios update.

Regarding WRES data, a key issue of concern was noted with regard to recruitment which showed that white applicants were more than three times more likely to be recruited from a shortlisting stage than someone from a BAME background. The Board recognised the specific risks relating to race and disability discrimination under the Equality Act should Trust policies and practices not be in line with legislation as well as risks to the Trust's approach to attraction and retention of staff.

Lynne referred to the plans as part of the Trust's 'Give Respect, Get Respect' campaign which will be an important tool for further work to be undertaken to build on supportive measures to enable constructive challenge where discrimination may be taking place and establish solutions and interventions to enable positive change.

Ken Jarrold recognised the progress made regarding disciplinary triaging. Despite this, Ken expressed concern in relation to recruitment and progression of nursing staff and the disparity between white nursing staff and nursing staff from a BAME background which represented a significant challenge and key priority for the Trust including issues such as unconscious bias.

Lynne also advised that the Trust would be commissioning the support of Roger Kline, a national expert on workforce culture and addressing issues of inequality.

Resolved:

- **The Board received the WRES, WDES and Disparity Ratio Report**

Regulatory

17. CNTW Disciplinary Policy

Lynne Shaw presented to the report and noted that in July 2019, the Board of Directors received a paper on Improving People Practices which outlined a national requirement for all Trusts to review their current disciplinary processes to take into account a number of recommendations identified as part of an independent review commissioned following the sad death of Amin Abdullah in 2016 which followed a protracted disciplinary procedure whilst working at a London NHS Trust.

Lynne advised that the Trust had undertaken a comprehensive consultation exercise with a wide range of staff and forums, including Staff Networks, which resulted in an action plan developed to strengthen further Trust processes regarding disciplinary processes.

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NHS England/NHS Improvement have now asked all NHS organisations to present their Disciplinary Policies to a Board meeting held in public and the policy uploaded to the Trust's website.

Resolved:

- **Board received the CNTW Disciplinary Policy and agreed the policy for publication on the Trust's website**

Board sub-committee minutes and Governor issues for information

18. Quality and Performance Committee

No meetings had been held since the last update to the Board

19. Audit Committee

No meetings had been held since the last update to the Board

20. Resource and Business Assurance Committee

No meetings had been held since the last update to the Board

21. Mental Health Legislation Committee

No meetings had been held since the last update to the Board

22. Provider Collaborative Committee and Terms of Reference

No meetings had been held since the last update to the Board

23. CEDAR Programme Board

No meetings had been held since the last update to the Board

24. Charitable Funds Committee

No meetings had been held since the last update to the Board

25. Council of Governors issues

Ken Jarrold advised Board members that Fiona Grant would be stepping down from her role as Lead Governor on 30th November and a process had commenced to appoint to the role. Ken thanked Fiona for her dedication to the role, the support she had given to her Governor colleagues and for her support to him personally as Chairman of the Council of Governors.

Ken provided an update on the recent appointment of two new Non-Executive Directors following approval of the Council of Governors at the meeting held 11th August. Ken was delighted to announce that Brendan Hill and Louise Nelson had been appointed as Non-Executive Directors to commence in post 1st October 2021.

Brendan had recently stood down as Chief Executive of Concern Group, which includes Mental Health Concern, Insight IAPT, and various projects and partnerships that are all focused around improving the mental health and wellbeing of the people across the region. He is passionate about mental health and wellbeing and began his professional career at St Nicholas Hospital as a Mental Health student nurse in 1986.

Louise is currently a Non-Executive Director at North Cumbria Integrated Care NHS Foundation Trust and is a Trustee for MIND, Carlisle and Eden. Louise has experience as a

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Non-Executive Director including Chair of the Quality and Safety Committee, as well as maintaining her registration as a qualified Mental Health Nurse. Louise worked as a Mental Health Nurse and her final clinical post was Head of Adult Services for North Cumbria. Louise has also worked in Nursing Education and her final post was Head of Department Nursing, Health and Professional Practice at the University of Cumbria.

Ken advised that unfortunately, due to unforeseen circumstances the appointment of the third Non-Executive Director had to withdraw their acceptance of the conditional acceptance of the post. The Governors' Nomination Committee would meet again to discuss next steps regarding recruit into this role.

Recognising the Board discussion at the meeting and concerns in relation to workforce and operational pressures, a meeting of the Council of Governors was scheduled to take place on 15th September to discuss the workforce challenges and action being taken.

26. Any Other Business

Nothing to report.

27. Questions from the public

None to note.

Date and time of next meeting

Wednesday, 6 October 2021, 1.30pm via Microsoft Teams

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Board of Directors Meeting held in public

Action Log as at 6 October 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.	Agenda item	Action	By Whom	By When	Update/Comments
Actions outstanding					
04.08.21 (21)	Carers' Charter	Update on the effectiveness, reach, monitoring and evaluation of the Carers' Charter	James Duncan	October 2021	Verbal update to be provided at the meeting under action log
04.08.21 (21)	North Cumbria PALs service	Provide an update on progress to establish a PALs service in the North Cumbria locality	James Duncan/ Ramona Duguid	October 2021	Verbal update to be provided at the meeting under action log
26.05.21 (5)	Access to support and services by telephone	Undertake a review of telephonic access points into the Trust to incorporate issues identified in complaints/feedback from service users	Ramona Duguid	October 2021	Verbal update to be provided at the meeting under action log
04.08.21 (10)	Quality priorities 2021/22	Discuss at a future Board Away Day the wider issues impacting on the service development programme going forward	Ramona Duguid	November	On track
04.08.21 (10)	Quality priorities 2021/22	Additional narrative to be provided in the Q2 report clarifying the approach to monitoring waiting times given the absence of a national definition	Lisa Quinn	November	On track
04.08.21 (10)	Quality priorities 2021/22	Provide an update to the Board and Governors clarifying the services provided within each of the Trust four localities	Ramona Duguid	November 2021	On track
01.09.21 (13)	Quarterly workforce report	Themes from exit interviews to be included in future reports	Lynne Shaw	December 2021	On track

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Item No.	Agenda item	Action	By Whom	By When	Update/Comments
Completed Actions					
04.08.21 (10)	Quality Priorities 2021/22	Provide a brief to clarify the definition of out of area placements	Lisa Quinn	September 2021	Complete – briefing included under matters arising

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
6th October 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)	
Quality and Performance	N/A
Audit	N/A
Mental Health Legislation	N/A
Remuneration Committee	N/A
Resource and Business Assurance	N/A
Charitable Funds Committee	N/A
CEDAR Programme Board	N/A
Other/external (please specify)	N/A

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

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

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

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Coronavirus (COVID-19)
Report for the Board of Directors meeting
6th October 2021

1. Executive Summary

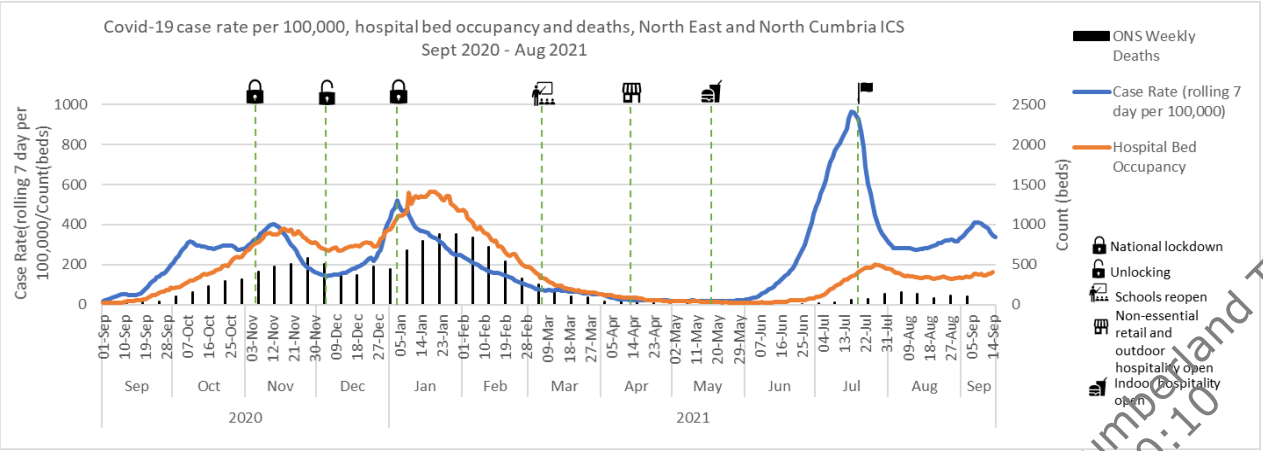
This report provides an exception report in response to the COVID-19 pandemic since the last Trust Board. For this month the report focus is on:

- COVID-19 Prevalence, Surge and Business Continuity
- Updated PHE guidance on NHS staff and student self-isolation and return to work following COVID-19 contact
- Nosocomial & Outbreak Management
- Vaccination Booster Programme and Vaccinations for 12-15year olds
- National Consultation - Mandatory Covid Vaccinations for Health and Social Care Staff.

2. Trust COVID-19 Prevalence

The September report highlighted a significant reduction in Covid cases across the North East & Cumbria (NE&C) region. Local rates per 100,000 at the time of this report (21.09.21) shows a stable situation although cases continue to be relatively high in that cases have not reduced to the level in April / May 2021. Cumbria has seen the largest increase in cases (data in brackets from previous monthly report).

- **Newcastle 312.2** (283.9)
- **South Tyneside 327.5** (293.8)
- **North Tyneside 378.7** (323.2)
- **Cumbria 401.6** (280.7)
- **Gateshead 311.5** (291.7)
- **Sunderland 282.2** (239)
- **Northumberland 325.5** (283.5)
- **Middlesbrough 364.5**



Whilst cases appear to be levelling off, the situation remains volatile as restrictions are eased. In most localities we continue to see an increase in cases in the 60-70 year age group.

Schools have reopened and supervised LFT testing was provided in schools at the start of term. Children and young people will continue to be tested at home and classes will not isolate where one positive case is identified unless a threshold is exceeded. Since the start of September, we have seen an increase in household cases but not experienced a surge of cases associated with schools

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reopening at this time, however this may still emerge over the coming weeks. Freshers' weeks for each of our regional universities may also have an impact over the next 3-4 weeks in driving up community prevalence and local authorities are monitoring very closely.

3. Surge and Business Continuity

NE&C hospitals continue to see the same level of hospital admissions as in last month's report. An increasing number of people who have been double vaccinated are being admitted to hospital and across the age range including some children.

The whole system e.g. Acute medical admissions, Emergency Departments, Primary Care, NEAS and Mental Health and Disability providers continue to experience immense pressure due to a combination of non-covid presentations and demand on services, coupled with the impact of staff absence.

Within CNTW, daily call volume into the absence line has continued to increase, and at the time of this report, we continue at Opel level 2 attributed to Covid, non-covid absence and vacancies impacting on business continuity across several service areas.

To ensure we can target support effectively to those areas experiencing business continuity pressures:

- An escalation tool has been developed during this period to support reallocation and redeployment.

- Additional targeted support for emotional health and wellbeing for staff is in place and enhanced support available was shared at a recent managers meeting.

- Due to increased pressure in clinical services, the decision taken to stand down non-essential meetings to free up capacity has been further reviewed.

- Recruitment activity to support vacancies continues to be prioritised.

4. Updated PHE guidance on NHS staff and student self-isolation and return to work following COVID-19 contact

The last report outlined our response to guidance which enabled Trusts to return Health staff from isolation to work if a close contact identified by the NHS Test and Trace App. This applies to people who have been double vaccinated.

In accordance with the new guidance regarding health and social care staff, on a case by case basis, IMG have agreed on the advice of the DIPC, to return **all staff** to work who have been identified as a close contact where the close contact is a non-household member. There is careful consideration of the staff member's place of work and their contact with patients and staff who are 'highly vulnerable' in accordance with the guidance. The staff member must also not be symptomatic. Following a negative PCR test they can return to work and continue to conduct daily LFT for up to 10 days instead of isolating

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Staff identified as a close contact of a positive household member or where staff have not been double vaccinated, will not return to the workplace but can continue to work from home if the role allows. The individual will be required to isolate from work for the 10 days at home. They will, however, not need to isolate at home and will be able to go about their usual business outside of the workplace environment.

Since this protocol was introduced on 13th September staff are now returning safely back to work within 48/72 hours and this has significantly increased the number of staff available for work. IMG will continue to review the position.

5. Staff only and Nosocomial Infections (Hospital Acquired) & Outbreak Management

Since the last meeting, four Outbreaks have been closed: Testing Team, SNH Switchboard, Lotus and Mowbray.

Five Outbreaks remain of which four are in the dormant stage of the Outbreak process and due to close in the following week.

Staff only Outbreaks

ICTS: Outbreak declared on 02.09.21. Three staff involved in the outbreak and all staff share an office and worked together on 25.08.21. Close Contact Risk Assessments indicated staff share phone and don't always wipe after use. All three staff had removed masks frequently during the shared shifts during the infectious period of the index case.

Sunderland CTT: Outbreak declared on 07.09.21. Three staff are identified as positive in this outbreak. Staff gathered at social event on 28.09.21. One staff member tested positive on LFT on 02.09.21 but did not isolate, report and continued to work whilst symptomatic. Lapses in consistent IPC / PPE practice in workplace identified including not adhering to room occupancy and taking meal breaks together in the office

Nosocomial Spread outbreaks

Embleton: Outbreak declared on 28.08.21. Five patients were identified as positive and linked to the outbreak. Patient activity outside of the ward whilst on leave and patient close contact during activities identified as root cause, then spread due to close contact with other patients (Nosocomial spread). Donning and doffing practice reinforced, cleaning of touchpoints and seating arrangements reviewed in patient dining area.

Ward 1, WGP: Outbreak declared on 29.08.21. Two patients identified as positive and four staff. A further four patients identified as having close contact during a ward activity with the positive patient were isolated. Decision made to isolate all patients as a precautionary measure. The root cause indicates a member of staff came into work whilst symptomatic, and the wearing of general PPE, donning and doffing practice and poor ventilation in rooms contributed to the hospital acquired case. There has been a significant amount of learning as a consequence.

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PICU, Ferndene: Outbreak declared on 08.09.21. This is a large outbreak involving all four patients. Three patients have tested positive, and one patient is isolating due to close contact with staff. The patient transmissions are regarded as nosocomial (hospital acquired) infections. A further eight staff have returned a positive result linked to the outbreak and two staff who were deemed not to be associated with the outbreak. The staff absence has had a huge impact on business continuity. Concerns regarding IPC practice and PPE have been identified and a robust action plan is in place with an increased level of senior visibility and leadership in place. IPC staff are actively involved in providing support and advice. Regular IMG meetings are taking place to manage and stabilise the situation.

Learning from the outbreaks indicates staff are not always adhering to maximum occupancy of rooms. Poor practice standards re: donning and doffing practice has been a theme and staff coming into work whilst symptomatic has also been identified as a significant factor in two of the outbreaks.

IPC team have developed and issued a presentation to be cascaded to all teams (corporate and clinical) via team briefings to support discussions regarding practice.

6. <u>COVID-19 Vaccination Booster Programme</u>

Our winter vaccination campaign launches on Monday 27th September, and we will be co-administering COVID-19 booster and flu vaccines, following the latest guidance. We hope that staff take this opportunity to come together as a Trust once again, doing our bit to protect our communities and keep ourselves well.

- As always, **we will be offering the flu vaccine to every member of staff at CNTW and NTW Solutions.**

- The Joint Committee on Vaccination and Immunisation (JCVI) issued updated advice that booster vaccines should be offered to those more at risk from COVID-19, who were vaccinated during Phase 1 of the vaccine programme, which includes healthcare workers. This means all fully vaccinated CNTW and NTW Solutions staff will be eligible for Covid boosters. This includes students and clinical partners.

We plan to run clinics to co-administer the COVID-19 booster and flu jab.

- As staff become eligible for the COVID-19 booster (which becomes due six months after the date of your second COVID-19 vaccine dose), they will be sent an email and Text asking them to book a clinic slot. We have arrangements to support staff without frequent access to emails to book their vaccinations.

- Not all staff will receive their booking invite at the same time – it will be based on when your COVID-19 booster is due. Staff can now check when your COVID-19 booster is due on 'My Workforce Information' dashboard.

- Clinics will be running from the following locations from Monday 27th September until 22nd October:

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- Keswick House, St Nicholas Hospital
- Druridge ward, St George's Park
- Meadowview, Hopewood Park
- Edenwood, Carleton clinic

- Further 'mop-up' clinics will be delivered in late November/early December.

- Staff will be offered the flu vaccine at the same appointment as the COVID-19 booster.

Our target this year is to vaccinate all our eligible staff and patients

6.1 COVID-19 Vaccinations of healthy young people aged 12-15 years:
The Government has accepted the UK CMOs' recommendation to extend the offer of universal vaccination with a first dose of the Pfizer vaccine to all children and young people aged 12 to 15 (who are not already covered by existing JCVI advice).

Local school aged immunisation service (SAIS) providers are to operationalise delivery of COVID-19 vaccinations in school settings and make specific provision available for those children aged 12-15 who are not in mainstream education. CNTW has arrangements in place to vaccinate young people currently in our inpatient children's services who are not already covered by existing JCVI advice.

7. Consultation re: mandatory vaccinations of health and social care staff.
A national consultation is underway to seek views regarding mandatory Covid vaccinations for all health and social care staff.

The aim of this consultation is to seek views on whether the government should extend the existing statutory requirement for those working or volunteering in a care home to be vaccinated against coronavirus (COVID-19) to other health and care settings, as a condition of deployment, and in addition, whether to introduce a statutory requirement to be vaccinated against the flu as a condition of deployment, to protect vulnerable people. The Trust is encouraging staff to engage in the consultation, and we will also ensure a trust response.

8. New National IPC guidance Consultation – Healthcare settings
At the time of writing the report we were expecting a revision of the existing guidance to determine future IPC Control measures required for Healthcare settings over the winter months as we live with Covid. This is expected to include other respiratory viruses. Further details will be provided for the Board in the next update.

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

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

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
6th October 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	29.09.2021
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	20.09.2021
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		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 5 (August 2021)

Executive Summary

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

2 An unannounced focused visit to Hopewood Park took place during August to monitor the use of the MHA and compliance with the Code of Practice for patients nursed in prolonged seclusion or long term segregation. Shoredrift, Springrise, Beckfield and Aldervale wards were visited by the CQC inspector. Feedback from these visits include; poor discharge planning, poor record keeping and capacity reviews regarding medication were not completed at appropriate times.

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 5 with the exception of:

- CPA metrics for all CCG's with the exception of Newcastle Gateshead, North Tyneside, South Tyneside, Durham, Darlington and Tees and North Cumbria.
- Numbers entering treatment within Sunderland IAPT service (567 patients entered treatment against a target of 810) and North Cumbria (367 patients entered treatment against a target of 605).
- Delayed Transfers of Care within South Tyneside, Sunderland, Durham, Darlington and Tees and North Cumbria.
- MHSDS Valid Ethnicity within North Tyneside.

4 The Trust met all the requirements for month 5 within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (96.8% 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 53 people waiting more than 18 weeks to access services this month in non-specialised adult services (19 reported last month). Within children's community services

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there are currently 991 children and young people waiting more than 18 weeks to treatment (824 reported last month).

7 Training topics below the required trust trajectory as at month 5 are listed below:

Training Topic	Month 5 position	Quarter 2 trajectory	Quarter 2 standard
Information Governance	90.7%	95%	
PMVA Breakaway training	75.7%	82%	
Mental Health Act combined	62.8%	83%	
Clinical Risk and Suicide Prevention training	82.8%	85%	
Clinical Supervision	80.4%	84%	
Seclusion training	69.1%	85%	
Rapid Tranquilisation	78.6%	85%	
Safeguarding Children Level 2	82.7%	85%	
Safeguarding Children Level 3	75.2%	84%	
PMVA Basic training	42.5%	Under review	
Fire Training	83.0%	85%	
MHCT Clustering	61.3%		85%

8 Appraisal rates are reported at 73.7% in August 2021 (75.4% last month), the recovery trajectory for Quarter 2 is 80% Trustwide

9 The percentage of staff with a completed clinical supervision record is reported at 44.0% as at 31st August 2021. At 31st August 2021 the proportion of staff with a management supervision recorded in the last 3 months is reported at 53.9% against a recovery trajectory of 81% for Quarter 2 2021.

10 The confirmed July 2021 sickness figure is 6.9%. This was provisionally reported as 6.95% in last month's report. The provisional August 2021 sickness figure is 7.01% which is above the 5% standard. The 12 month rolling average sickness rate has increased to 5.84% in the month.

11 At Month 5, the Trust has a surplus of £0.3m which is £0.2m ahead of plan. Agency spend at month 5 is £7.9m of which £4.7m (60%) relates to nursing support staff.

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Other issues to note:

- There are currently 20 notifications showing within the NHS Model Hospital site for the Trust.
- The number of follow up contacts conducted within 72 hours of discharge has increased in the month and is reported trust wide at 95.3% which is above the 80% standard. (was 93.7% last month).
- There were 31 inappropriate adult out of area bed days due to the unavailability of adult acute and adult older persons beds reported in August 2021. This related to three patients, two patients requiring an adult acute bed were admitted appropriately whilst away from home but were then subsequently classed as inappropriate when they were unable to be transferred back to CNTW.
- During August 2021 the Trust received 595 Points of You survey returns, of which 74% were from service users, 16% from carers, 6% were completed on behalf of a service user and 4% did not state the person type. Of the 595 responses 576 answered the FFT question with 89% 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, the Trust will recommence managing against the trajectories from 1st October 2021 (Quarter 3) which have now been reviewed for recovery post COVID within the Locality Care Groups and have been updated for Quarter 3 and 4.

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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"	
Outstanding	45	An unannounced focused visit to Hopewood Park took place during August to monitor the use of the MHA and compliance with the Code of Practice for patients nursed in prolonged seclusion or long term segregation. Shoredrift, Springrise, Beckfield and Aldervale wards were visited by the CQC inspector.

Contract

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

NHS England	Northumberland CCG	North Tyneside CCG	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	North Cumbria CCG
94%	100%	80%	80%	80%	86%	75%	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: August 2021		Central Locality Care Group Score: August 2021		South Locality Care Group Score: August 2021		North Cumbria Locality Care Group Score: August 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: Month 4 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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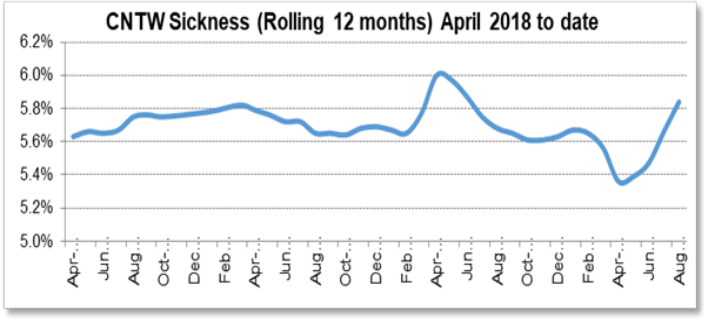
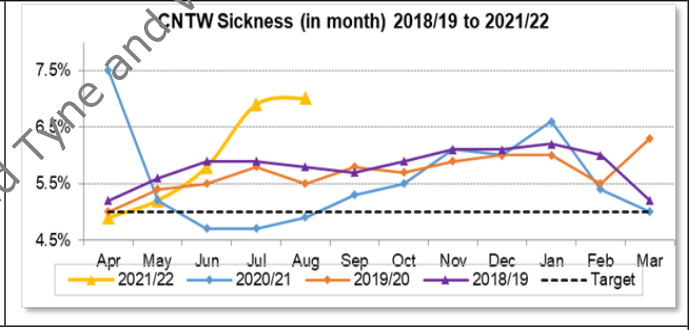
<table>
<tr><td></td><td colspan="5">Waiting Times
The number of people waiting more than 18 weeks to access services has increased in the month for non-specialised adult services. The number of young people waiting to access children's community services has remained the same in month 5. There are continuing 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.</td></tr>
<tr><td rowspan="3">Workforce</td><td colspan="3">Statutory & Essential Training:</td><td rowspan="2">Fire training (83.0%), Clinical Risk training (82.8%), Clinical Supervision training (80.4%), Safeguarding Children Level 2 (82.7%) and Information Governance (90.7%) are within 5% of the Quarter 2 trajectory. Rapid Tranquilisation training (78.6%), PMVA basic training (42.5%), PMVA Breakaway training (75.7%), MHA combined training (62.8%), MHCT Clustering Training (61.3%), Seclusion training (69.1%) and Safeguarding Children Level 3 (75.2%), are reported at more than 5% below the Quarter 2 trajectory.</td><td rowspan="2">Appraisals:
Appraisal rates have decreased in the month to 73.7% in August 2021 (was 75.4% last month).</td></tr>
<tr><td>Number of courses Trajectory Achieved Trustwide:</td><td>Number of courses <5% below trajectory Trustwide:</td><td>Number of courses trajectory not achieved (>5% below standard):</td></tr>
<tr><td>7</td><td>5</td><td>7</td></tr>
<tr><td></td><td colspan="5">Sickness Absence:</td></tr>
<tr><td></td><td colspan="2"> 
</td><td>The provisional "in month" sickness absence rate is above the 5% target at 7.01% for August 2021

The rolling 12 month sickness average has increased to 5.84% in the month</td><td colspan="2"> 
</td></tr>
<tr><td>Finance</td><td colspan="5">At Month 5, the Trust has a surplus of £0.3m which is £0.2m ahead of plan. Agency spend at month 5 is £7.9m of which £4.7m (60%) relates to nursing support staff</td></tr>
</table>

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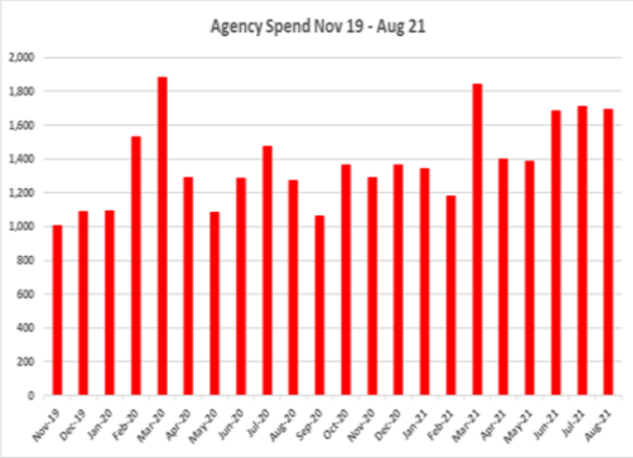
Financial Performance Dashboard

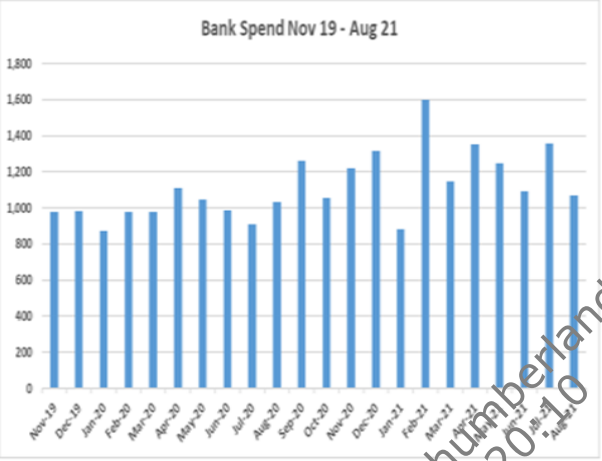
Income & Expenditure

	Plan £m	Actual £m	Variance (£)
Income	202.1	202.2	(0.1)
Pay	(144.0)	(144.4)	0.4
Non Pay	(58.0)	(57.5)	(0.5)
Surplus / (Deficit)	**0.1**	**0.3**	**(0.2)**

Key Indicators

Key Indicators	Year To Date
Surplus/ (Deficit)	£0.3m
Agency Spend	£7.9m
Cash	£60.1m
Capital Spend	£13.5m





Key Issues/Risks

- At month 5 the Trust has a £0.3m surplus.
- Income arrangements are a continuation of the block contracts implemented in 2020/21 in response to COVID. These arrangements will continue for the rest of the year.
- 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 – £60.1m at month 5 which is more than historical cash levels (pre-COVID) due to improved working balances, capital spend being less than plan in 2020/21 and this year and increases in provisions.
- Capital Spend - £13.5m at month 5 which is £5.4m less than plan.

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

	02/08/2021		09/08/2021		16/08/2021		23/08/2021		30/08/2021	
Medical	76	36	92	41	107	41	107	46	109	53
Qual Nursing	188	177	189	178	189	178	173	162	164	149
Unq Nursing	1,613	100	1,815	91	1,807	94	1,658	94	1,707	74
A&C	92		84		91		86		60	
	1,969	**313**	**2,180**	**310**	**2,194**	**313**	**2,024**	**302**	**2,040**	**276**

In August the Trust reported an average of 303 price cap breaches (43 medical, 169 qualified nursing and 91 nursing support). At the end of August 11 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 month 5 and 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	Lisa Quinn
Deputy Director of Commissioning & Quality Assurance	Executive Director of Commissioning & Quality Assurance
21st August 2021	

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Training Trajectories 2021-2022 – Appendix 1

		Q1						Q2					
Metric ID - Training Name	Standard	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%	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	Standard	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%	75%	80%	84%	85%	85%	85%	85%	85%	85%
3002 - Clinical Supervision	85%	85%	83%	85%	72%	85%	83%	85%	85%	85%	85%	85%	85%
3004 - Equality & Diversity Introduction	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3006 - Fire	85%	85%	85%	85%	82%	85%	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%	85%	85%	85%	85%	85%	85%	85%	85%
3018 - Medicines Management Training	85%	85%	85%	85%	78%	80%	84%	85%	85%	85%	85%	85%	85%
3019 - Moving & Handling Awareness Training	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3022 - PMVA Basic	85%	72%	50%	60%	50%	65%	61%	80%	60%	70%	60%	65%	68%
3023 - Rapid Tranquilisation Training	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3026 - Safeguarding Adults Level 1	85%	85%	85%	85%	85%	85%	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%	85%	95%	94%	95%	95%	95%	95%	95%	95%
3042 - Seclusion Training	85%	85%	85%	85%	75%	85%	84%	85%	85%	85%	85%	85%	85%
3043 - PMVA Breakaway	85%	83%	82%	85%	80%	75%	83%	85%	85%	85%	85%	85%	85%
3046 - Safeguarding Children Level 3	85%	85%	85%	85%	73%	85%	80%	85%	85%	85%	85%	85%	85%
3047 - Safeguarding Children Level 2	85%	85%	85%	85%	75%	85%	84%	85%	85%	85%	85%	85%	85%
3075 - MHA MCA DoLS Combined	85%	74%	82%	80%	60%	70%	75%	82%	85%	85%	85%	85%	85%
3501 - Complete JDR's	85%	77%	78%	85%	73%	80%	80%	85%	80%	85%	85%	85%	85%
3514 - Proportion of staff with management supervision recorded in the past 3 months	85%	76%	85%	85%	55%	85%	79%	85%	85%	85%	85%	85%	85%
1933 Percentage of employees with up to date Clinical Supervision records	85%	69%	60%	70%	50%	85%	70%	85%	80%	85%	85%	85%	84%
Dysphagia Awareness	85%	80%	85%	85%	72%	85%	83%	85%	85%	85%	85%	85%	85%
3089 - Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	85%	85%	70%	70%	50%	75%	80%	85%	85%	85%	85%	85%	85%
3092 - Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	85%					85%	85%					85%	85%
3093 - Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	85%	72%	45%	65%	58%	75%	63%	80%	55%	70%	85%	85%	75%
3094 - Resuscitation - Level 3 - Paediatric Immediate Life Support - 1 Year	85%			85%	58%		64%			85%	60%		67%

The yellow shaded trajectories reflect where the standard has been reviewed during September 2021.
The grey shaded boxes indicate where the metric is not applicable.

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Quality Trajectories 2021-2022

		Q1					Q2				
Metric ID - Quality	Standard	North	Central	South	N.Cumbria	Aggregate	North	Central	South	N.Cumbria	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%	94%	93%	95%	83%	91%	94%	95%	95%	90%	94%
156 Current Service users clustered within threshold (previous 2 reviews)	85%	85%	85%	80%	63%	78%	85%	85%	85%	65%	80%
157 Current service users clustered within review threshold	85%	85%	85%	80%	74%	81%	85%	85%	85%	80%	84%
11 % of service users with a record of CPA/non CPA status	95%	93%	95%	85%	74%	87%	94%	95%	95%	80%	91%
34 Current service users on CPA reviewed in last 12 months	95%	95%	95%	95%	80%	91%	95%	95%	95%	95%	95%
401 CPA reviews where cluster performed +3/-3 days either side of CPA review	85%	78%	83%	80%	49%	73%	85%	85%	85%	50%	76%
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%	75%	86%	90%	90%	90%	80%	88%
298 DTOC	<7.5%				12%	12%				12%	12%
101 Risk Assessments	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
102 Crisis Plans	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
1085 Current Service Users with Identified Risks who have a 6 Monthly Crisis and Contingency Plan - NHS England Services only	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
1402 Number of CYPS (AMS) Service Users with a recorded CGAS on entry to service and discharge (Planned discharges only)	80%	80%	80%	80%	85%	81%	80%	80%	80%	85%	81%
1403 Number of CYPS (AMS) Device Users with a recorded Honosca on entry to service and discharge (Planned discharges only)	80%	80%	80%	80%	50%	73%	80%	80%	80%	85%	81%
1409 Number of CYPS (AMS) Device Users with a recorded GBO on entry to service and discharge (Planned discharges only)	80%	80%	80%	80%	50%	73%	80%	80%	80%	85%	81%

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NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
6th October 2021

Title of report	Annual Report for Safeguarding and Public Protection 2020–2021
Report author(s)	Acting Team Manager Safeguarding and Public Protection / Named Nurse – Sheona Duffy Claire Thomas – Associate Director – Safer Care
Executive Lead (if different from above)	Rajesh Nadkarni Executive Medical Director

Strategic ambitions this paper supports (please check the appropriate box)

Work with service users and carers to provide excellent care and health and wellbeing	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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Key Points to Note:

- The Trust Safeguarding and Public Protection annual report covers the period from April 2020 to March 2021.

- Safeguarding is fundamental to all work of the trust. This report provides assurance that the trust is fulfilling its statutory safeguarding responsibilities and demonstrates a strong commitment to working together within all aspects of safeguarding and public protection.

- Safeguarding and public protection activity remains constant with cases identified across the Trust having high levels of vulnerability and complexity. We have been mindful that the pandemic has also increased vulnerabilities and hidden harms for our service users, for example increase in Domestic Violence on national level.

- The trust has exceeded its training target percentage set by NHS England of staff trained in Prevent.

- Embedding signs of safety (SOS) to ensure that children's safeguarding is bespoke to the needs of that child and capturing their individual voice, and a strengths-based approach to safeguarding has been a priority for local partners. The multi-agency training provided by partners has been cascaded to the four localities and the safeguarding practitioners.

- Throughout the pandemic CNTW has engaged with each safeguarding board to provide assurance that we continued to provide safe care and treatment for our service users.

- Throughout the pandemic safeguarding training has been available through eLearning systems and virtual training events. NHSE has continued to provide via Bond Solon specialist safeguarding training.

- The report outlines the progress that has been made in safeguarding the health and wellbeing of patients and carers. It highlights areas where the safeguarding and public protection team are continuing to develop and offers an insight into the safeguarding priorities for the organisation.

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Safeguarding and Public Protection

Annual Report

2020/2021

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Introduction

This annual report gives an account of the safeguarding activity across Cumbria, Northumberland Tyne and Wear NHS Foundation Trust. The report covers the period April 2020 – March 2021. It demonstrates the organisations commitment to protecting children, young people and adults at risk of harm across all service areas.

Safeguarding activity across the Trust continues to increase in volume and complexity. Safeguarding concerns are positively being recognised more frequently across clinical areas. All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults at risk and to assure themselves, regulators and their commissioners that these are working. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor and a Named Nurse.

Ultimately the Trust Board requires assurance that the organisation is fulfilling its obligations to safeguard and promote the welfare of children and vulnerable adults. Throughout this reporting period, we have faced unprecedented times of an international pandemic, however we have continued to deliver upon the safeguarding agenda.

"Safeguarding is everybody's business"

Safeguarding and Public Protection Team

The Safeguarding and Public Protection service consists of a Team Manager/ Named Nurse, six Senior Nurse Practitioners, Case Review Report Writer, two MASH post, Safeguarding and Public Protection Development Officer and the Police Liaison Nurse who bring a variety of safeguarding and public protection expertise, skills and experience. They are supported by the Safer Care Administration Team.

The core functions of the team are:

- To provide clinical leadership in respect of safeguarding to support high quality safeguarding and public protection practice for children and adults.
- To provide a "triage" service for all safeguarding and public protection concerns raised within the organisation to ensure the individual is safeguarded and effective safety plans are in place.
- Sharing learning from internal and external reviews of cases and best practice.
- To provide support and advice on complex cases.
- To attend MARAC (Domestic Abuse meetings), MAPPA and Prevent (public protection) multi-agency meetings on behalf of the trust.
- Provide strategic advice and leadership through the involvement in Safeguarding Practice Reviews, Safeguarding Adult Reviews and Learning Lesson Reviews.

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- To provide challenge and scrutiny of safeguarding and public protection practice including the interface with statutory agencies.

- To provide oversight and development of policy and procedures.

- To provide strategic vision in respect of safeguarding and public protection.

- To provide high quality supervision and check that supervision delivered across the organisation is in line with evidenced based practice.

- To support individuals working with adults at risk to practice in adherence to the six safeguarding principles.

The Safeguarding and Public Protection Team aims to support all trust staff to keep children, young people and adults at risk, safe and to meet statutory obligations. We promote collective accountability in all that we do, working together to prevent all forms of abuse or neglect.

A commitment to safeguarding children and adults is evident at all levels within the organisation. The Trust has a clear and consistent structure in place to ensure scrutiny and challenge of safeguarding arrangements and consideration of the impact on the people who use services.

Key achievements 2020/2021

- ✓ Contributed to the development of each localities strategic safeguarding agenda.

- ✓ Created a strong and productive working relationship with Cumbria safeguarding board.

- ✓ Reviewed and stopped the MARE process in North Cumbria and brought community risk management in line with national standards.

- ✓ We continued to work with prioritising the PREVENT agenda.

- ✓ Embedded two new posts in the Sunderland and Northumberland Multi Agency Safeguarding Hub (MASH) posts within the team. Northumberland as a substantive post and Sunderland continues to be on non re occurring funds.

- ✓ Throughout the pandemic we have delivered a full uninterrupted SAPP service.

Operational Management Developments

- Closer working relationships with the locality groups - SAPP practitioners now attend locality safety meetings to facilitate sharing of learning and improved communication.

- MASH in two localities has been strengthened by the development of two dedicated

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posts to sit within the MASH. These posts will ensure that vulnerable people with mental health and learning disabilities will get the correct service at the right time from the right professional.

- We have supported the opening of Acklam Road Hospital and Lotus ward, in the context of re commissioning of regional specialist inpatient beds for young people.

- We have maintained strong multi-agency cooperation to Counter terrorism Policing (Special branch) and local authority Channel panel chairs within Cumbria and Northumbria Police area and the 7 CCG's that CNTW covers.

Safeguarding Assurance

The Safeguarding and Public Protection Group is a quarterly Trust Subgroup of the Trust Quality & Performance group. It is a governance and assurance group that support learning and practice development in safeguarding across Trust services and staff. The Safeguarding Group is chaired by Group Nurse Director Safer Care who brings challenge and scrutiny into the work of the group.

Through the pandemic in response to Trust business continuity planning meetings were stood down to ensure that delivery of front-line services. However internal trust assurance and reporting was provided through other forums:

- BDG Safety - weekly meetings – discussion of significant/complex safeguarding concerns.
- CDTQ Monthly Safer Care reports.
- Bi-monthly Trust Board reports for Case reviews.
- Quality and Performance Committee Quarterly Safer Care reports.
- Locality Care Groups Quality and Performance reports include a SAPP activity report.
- CCG quarterly Safeguarding Dashboard reports.

Safeguarding and Public Protection Data

There has been a significant increase (+12.9%) in Safeguarding and Public Protection concerns reported into the SAPP team during 2020/21 where 11326 incident reports were completed, compared with 100036 in 2019/20. The SAPP Practitioners review each report, liaising with services and recording on service user health records and the safeguard system.

This increase in safeguarding and public protection concerns is multi-faceted including a greater awareness of staff in recognising vulnerabilities through training; societal changes and increased deprivation; changes to early help and available support leading to greater unmet needs of children and families and an increase in prevalence of children and young people's mental health. A high level of domestic abuse incidents are evident across the localities we serve.

During 2020/21 all local authority areas hold a weekly MARAC, reflective of the expected increase in domestic abuse during the pandemic. There has been an additional 100 incidents of domestic abuse affecting CNTW service users.

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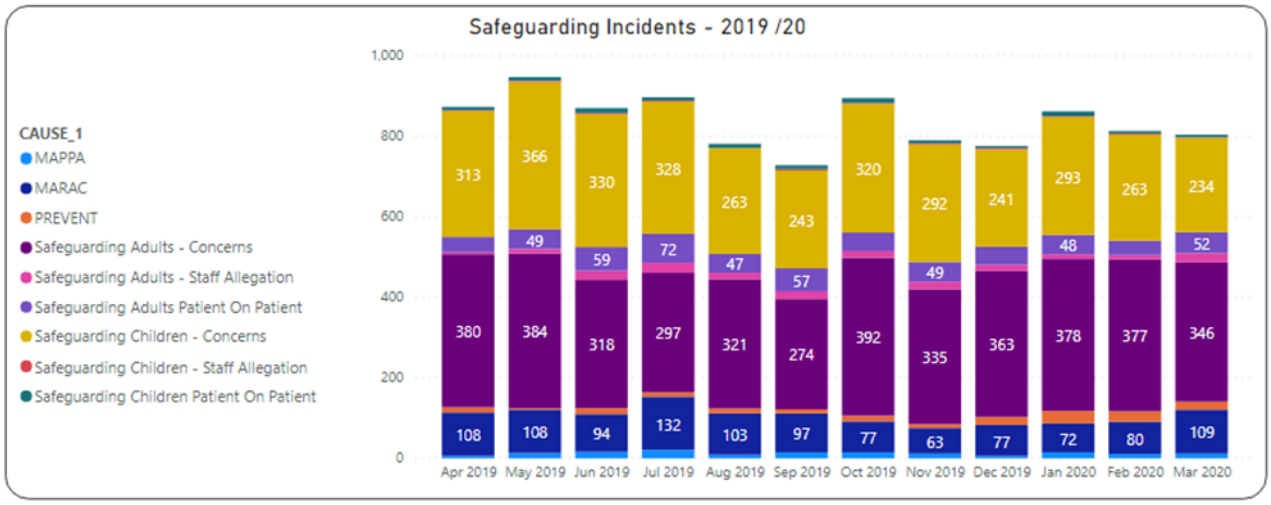
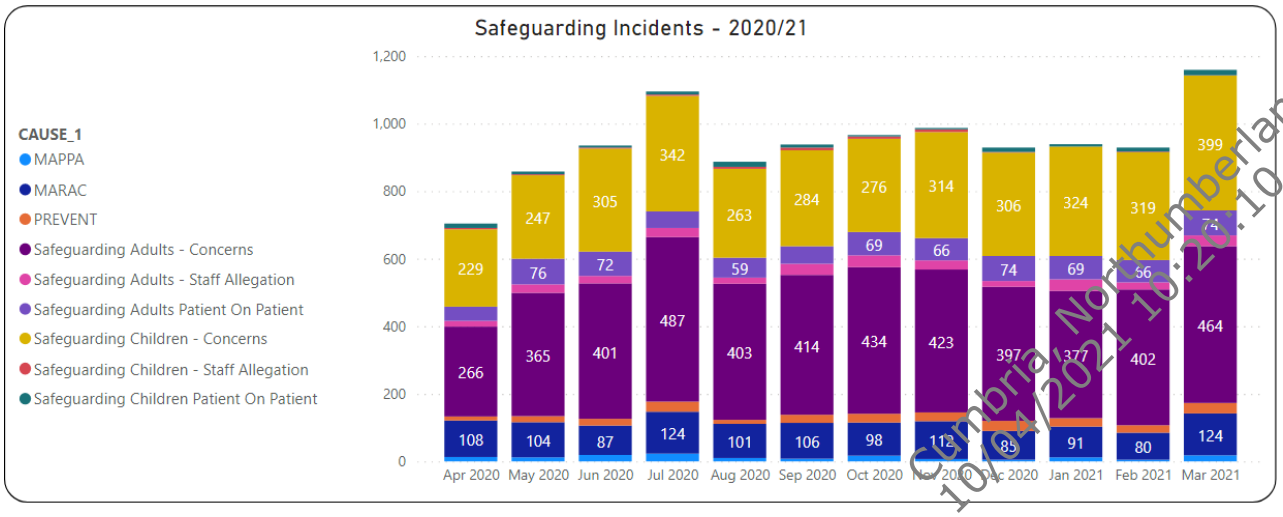
There has been a significant increase in the volume of referrals across the seven local authority areas. All referrals require information from CNTW to ensure a thorough assessment to be carried out and to enable appropriate support and safeguarding for individuals who are often extremely vulnerable.

Emotional harm continues to be the most reported type of abuse and includes the impact of parental mental health on children.

The SAPP team are receiving increased reports of young people and adults attending services with poor mental health and using substances and self-harm as a way to cope with this. This is being seen by other agencies such as police and social care.

Staff reports of patient-on-patient incidents have also increased which is reflective of the reported increased acuity seen by in patient staff.





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Safeguarding & Public Protection

CAUSE_1	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
Safeguarding Adults - Concerns	380	384	318	297	321	274	392	335	363	378	377	346	**4165**
Safeguarding Children - Concerns	313	366	330	328	263	243	320	292	241	293	263	234	**3486**
MARAC	108	108	94	132	103	97	77	63	77	72	80	109	**1120**
Safeguarding Adults Patient On Patient	38	49	59	72	47	57	46	49	45	48	36	52	**598**
Safeguarding Adults - Staff Allegation	5	11	23	25	16	19	17	19	15	11	11	23	**195**
PREVENT	13	4	15	11	12	10	14	10	20	31	26	20	**186**
MAPPA	6	13	16	21	9	15	15	12	6	15	11	12	**151**
Safeguarding Children Patient On Patient	8	9	12	8	10	9	12	7	5	12	6	6	**104**
Safeguarding Children - Staff Allegation	2	3	3	3		4	2	3	4	2	3	2	**31**
Total	**873**	**947**	**870**	**897**	**781**	**728**	**895**	**790**	**776**	**862**	**813**	**804**	**10036**

Safeguarding & Public Protection

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
Safeguarding Adults - Concerns	266	365	401	487	403	414	434	423	397	377	402	464	**4833**
Safeguarding Children - Concerns	229	247	305	342	263	284	276	314	306	324	319	399	**3608**
MARAC	108	104	87	124	101	106	98	112	85	91	80	124	**1220**
Safeguarding Adults Patient On Patient	42	76	72	49	59	52	69	66	74	69	66	74	**768**
Safeguarding Adults - Staff Allegation	17	25	22	27	18	33	35	27	17	34	21	32	**308**
PREVENT	12	18	20	30	12	24	26	26	30	25	22	31	**276**
MAPPA	13	12	19	23	10	8	17	7	5	12	5	18	**149**
Safeguarding Children Patient On Patient	13	8	6	9	15	9	4	4	13	7	12	16	**116**
Safeguarding Children - Staff Allegation	4	3	3	4	6	8	7	8	2		2	1	**48**
Total	**704**	**858**	**935**	**1095**	**887**	**938**	**966**	**987**	**929**	**939**	**929**	**1159**	**11326**

Our Commitment to Partnership Working

The safeguarding and public protection team continue work with all partner agencies and will contribute to multi agency safeguarding arrangements to ensure robust safety plans are in place. The Locality Care Groups and SAPP team work together to ensure there is appropriate representation at Safeguarding Partnership meetings, boards, and subgroups.

Clinical Police Liaison Lead (CPLL)

The Clinical Police Liaison Lead is an established role within the trust for 7 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.

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, working closely with Police colleagues around training, a gap analysis they have completed and 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. Links with British Transport Police remain and have expanded to cover the new areas also. The role has proven key during pandemic in being central point too share out and responds to developing need due to covid, ensuring support for police colleagues and our services around all matters required.

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.

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Training and education off new student officers have 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.

Police and Partner meetings have been stood down mostly during this time, but there still have been good and clear communication between Police and teams with support of the CPLL, and developments occurred where needed. There has been lots of work around developing unique joint plans to ensure all agencies involved with a person are aware from that person also of the best way to respond when in distress/crisis. This has been helpful particularly during lockdown and throughout the pandemic.

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 meetings has increased and often cannot get to all invited, so advice, information, or SAPP colleagues attend with Police where indicated.

Prevent

The CNTW SAPP Prevent role continues to be an instrumental aspect of the management of both the mental health and vulnerability factors with individuals who have been referred to Prevent. In 2020/21 referrals to Counter Terrorism Policing from CNTW were second only in number to those received from educational establishments.

Through the support afforded by the SAPP Prevent lead role it is clear that members of CNTW understand the key role safeguarding plays in Prevent and the requirement for early intervention, ensuring those vulnerable do not enter the criminal space.

Statistically it is apparent there has been a significant increase in the number of referrals, information sharing requests and attendances at Channel panels across the seven local authority areas. This increase equates to 48% over the period 2019-2020 and 2020-2021. That workload shows little sign of abating in the first quarter of this year.

It should be noted that every information sharing request from Counter Terrorism Police/Channel panel requires information from the SAPP Prevent lead for a thorough assessment to be carried out and to enable appropriate support and safeguarding for individuals who are often extremely vulnerable. Unlike other areas of SAPP work, such as MARAC or MAPPA, a case may have many contacts and discussions with partner agencies

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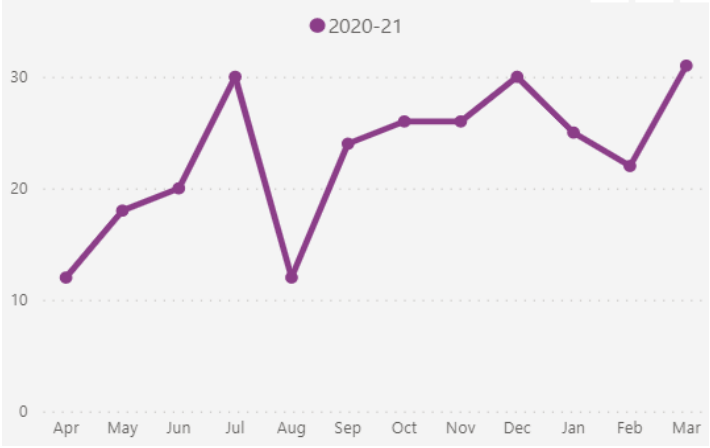
during the period a case is active. For example, one client in Northumberland who has been open to our services has been discussed in the Channel panel for the last 18 months.

Finally, the last 12 months have seen 4 individuals known to CNTW convicted of terrorism offences. It is expected that when these individuals near release from prison they will be managed at MAPPA level 3. Attendance at such meetings also form part of the SAPP Prevent lead's role.

Prevent Referrals 2020-21



External Assurance Audits

There have been no formal external audits during this year due to the pandemic response. However, we have continued to provide data and assurance where required and have completed internal CNTW audits for safeguarding adults and MARAC compliance.

Quality Assurance Framework (QAF) audits

The Trust also completes annual Quality Assurance Framework Audits in relation to their duties under the Care Act 2014 for safeguarding adults. This tool aims to assess the effectiveness of the arrangements for safeguarding adults at a strategic level. Assurance has been provided to the LSAB's that the trust is meeting its safeguarding adult responsibilities. A trust Director attended a challenge event in one locality. This promoted constructive challenge to trust safeguarding arrangements and provided assurance that the trust is meeting its safeguarding responsibilities.

External Inspections

Several OFSTED and CQC inspections have taken place within Local Authorities/health that the trust has supported with case information and attendance at focus groups and case scrutiny for the inspections.

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Raising Awareness
The trust communications team have supported Safeguarding and Public Protection through a range of information to staff this has included:

- Seven-minute briefings
- Safe Sleeping
- Domestic Violence for patients and staff (covid related)
- Learning from Case Reviews
- Prevent in line with national intelligence

The team also ensure any learning identified and any safeguarding campaigns/awareness raising information are available to all staff trust wide via the Safer Care Intranet page.

Training
The Trust has maintained compliance above the 85% set training target for the year for Safeguarding and Public Protection. Prevent training has exceeded the 90% target set by NHS England. Training requirements have been updated in line with the intercollegiate document. Level 3 face to face training for all professionally registered staff was placed on hold due to pandemic and we are now below target for this training.

Policies and Procedures
Safeguarding policies are in place and are accessible to staff via the Trust intranet. The seven Local Authority areas safeguarding, and public protection policies and procedures are also available via links on the staff intranet site. During the reporting period, SAPP policies are continually monitored and updated in line with local and national changes.

Case Reviews
The trust has continued to participate in statuary and non-statutory reviews

- Local Children Safeguarding Practice Reviews- (LCSPR)
- Safeguarding Adult Reviews (SAR)
- Domestic Homicide Reviews (DHR)
- MAPPA Serious Case Reviews (SCR)
- Appreciative Inquiries (adults and children multi agency reviews)

Over the last twelve months there has been 6 LCSPR, 5 SAR and 4 DHR commissioned where CNTW have been involved with the family.

All reviews are reported to the Trust Board on a bi-monthly basis and lessons learnt are cascaded throughout the organisation and/or built into future training. Bespoke training has also been provided for those service areas involved to ensure all staff have received the lessons learned.

The key areas of focus are outlined below. The areas of focussed learning have been shared via the Trust wide safer care bulletin and attending the locality safety meetings.

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- Safeguarding Children - Clinician's responsibilities to attend child protection meetings and our strategy responsibility to engage. We have updated the policy guidance provided to staff.

- Domestic Abuse - recognising and responding to domestic abuse, completion of MARAC check list and referrals and completing as standard on core documentation, risks in relation to domestic abuse.

- Public Protection - Concern expressed from carers should be taken very seriously and information used to assess risk to others.

- Safeguarding adults - The link between substance misuse, mental health and recognising and responding to self - neglect.

Annual Work Plan 2021/22

All the actions from the 19/20 Annual Work plan have been achieved.

The workplan for the SAPP team includes:

- Evaluation of the newly appointed CNTW MASH Practitioners and potential development of these posts within other localities if funding is available.

- Review and development of CNTW support to Prevent with local and national partners.

- Embedding local and national safeguarding priorities in our teams and services across CNTW including:

    - Transitional safeguarding
    - Signs of safety
    - Contextual safeguarding
    - The new Domestic violence bill

- Improving the data monitoring and quality assurance reporting of safeguarding data internally and to local partners.

- Reviewing Trust systems for learning lessons from safeguarding incidents that have occurred internally and externally to ensure that learning is shared and embedded.

- The Clinical Police Lead will continue to work closely with Cumbria Police to further enhance close working relationships with support of any new developments in conjunction with the Safeguarding Development Officer.

- The Clinical Police Liaison lead is continuing to look at data and doing more around Police activity data, to evidence what we do and how we do it, as well as look at demand and ensure capturing lessons learnt. Working with the Safer Care Business Manager a police activity dashboard is being developed to give us clearer and better understanding.

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Conclusion

This annual report provides the Trust Board, partners and stakeholders with an overview and assurance of the activity for Safeguarding and Public Protection during the periods 2020/21, including the learning from Case Reviews and investigations. The Safeguarding and Public Protection Team will be working with locality teams to ensure the learning is embedded in practice. The last 12 months have been unprecedented, the CNTWSAPP team have provided a reliable, consistent quality services ensuring that our staff and patients were safe.

The Team are looking forward to the year ahead in ensuring safeguarding and public protection is maintained as a high priority for the Trust and continues to be viewed as everyone's business.

Appendix 1 – Definitions

Local Child Safeguarding Practice Reviews (Previous Serious Case Review)

Serious child safeguarding cases are those in which:

- Abuse or neglect of a child is known or suspected; and
- The child has died or been seriously harmed.

The criteria which the local safeguarding partners must take into account when determining whether to carry out a local child safeguarding practice review includes whether the case highlights or may highlight:

- Improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
- Recurrent themes in the safeguarding and promotion of the welfare of children;
- Concerns regarding two or more organisations or agencies failing to work together effectively to safeguard and promote the welfare of children;
- Or is a case which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

Safeguarding partners should also have regard to the following circumstances:

- Where they have cause for concern about the actions of a single agency;
- There has been no agency involvement with the child / family prior to the incident and this causes for concern;
- More than one local authority, police force area or clinical commissioning group is involved, including in cases where families have moved around;

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- The case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings (this includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005).

Some cases may not meet the definition of a 'serious child safeguarding case' but the safeguarding partners may choose to undertake a local child safeguarding practice review because they raise issues of importance to the local area, for example good practice, poor practice or where there have been 'near miss' events.

Safeguarding Adults Reviews - SAR
(1) An Safeguarding Adult Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

Condition 1 or 2 is met.

(2) Condition 1 is met if:
(a) The adult has died, and

(b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if:
(a) The adult is still alive, and
(b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to -
(a) Identifying the lessons to be learnt from the adult's case, and
(b) Applying those lessons to future cases.

Care Act 2014.

Domestic Homicide Review – (DHR)
The guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act) 1

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The Act states:

(1) In this section “domestic homicide review” means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016

MAPPA - SCR

The SMB (Strategic Management Board) must commission a MAPPA SCR if both of the following conditions apply.

The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed.

The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

The purpose of the MAPPA SCR is to examine whether the MAPP arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to effectively manage the risk of further offending in the community.

MAPPA Guidance 2012 (updated 2019) Ministry of Justice.

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
6th October 2021

Title of report	**Safer Care Annual Report 2020/2021**
Report author(s)	**Anne Moore - Group Nurse Director Safer Care Damian Robinson – Group Medical Director Safer Care**
Executive Lead (if different from above)	**Rajesh Nadkarni – Executive Medical Director 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)	
Quality and Performance	X
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	X
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	
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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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Safer Care Directorate Annual Report 2020/2021

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INTRODUCTION

This is the fifth annual report of the Safer Care Directorate. It describes the achievements of the each of the main departments in 2020/21 along with their ambitions from the forthcoming year 2021/22.

The last year has been challenging as a result of the ongoing COVID pandemic. This required a refocussing of effort towards managing the pandemic while still ensuring that other core functions of the Directorate continued as far as possible. This has been successfully achieved.

New ways of working have been implemented, particularly the use of Microsoft Teams as a medium for conducting meetings which allow people working from home or other remote locations to join meetings, they would otherwise not have been able to. This medium has been used to conduct serious incident review panels facilitating greater engagement with clinical staff. While not without challenges, it is likely that new ways of working will continue post-pandemic.

There have been some organisational changes which have seen health and safety, security and resilience moving from the Safer Care Directorate. Executive leadership is now shared between the Executive Director of Nursing and the Executive Medical Director. However, this has not changed the need to work closely together on the important developments outlined in the NHS Patient Safety Strategy.

Our ambitions are linked to the Trust's overarching strategy '**Caring, Discovering, Growing'**, and remain:

- ✓ **To maintain a relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care and reducing avoidable harm.**
- ✓ **To work together**
- ✓ **To be committed to continuous Trustwide learning and improvement**
- ✓ **To be highly flexible and respond to any changes in the delivery of care**

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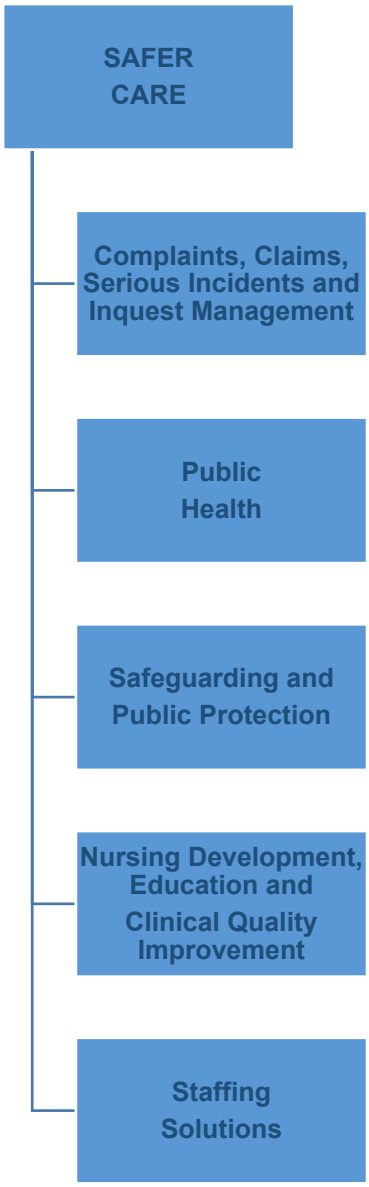
Safer Care Directorate functions:

The Safer Care Directorate delivers several functions which work together to deliver the overall Directorate ambition.



Sections 1 to 5 provide an overview of each function, the work undertaken and key achievements over the last 12 months. There is a hyperlink to a full annual report for those teams who provide a statutory function for the Trust.

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Section 1

Complaints, Claims, Serious Incidents and Inquest Management

This team is overseen by the Head of Clinical Risk and Investigations. The team manages the following functions of the Directorate: the investigation of serious incidents and inquest management; learning from deaths and the mortality review process; complaints management; and claims management.

Investigation of serious incidents and Inquest management

The team of serious incident investigators and administrative support have ensured that all serious incidents over the year have been identified and investigated, and that learning has been highlighted and disseminated to improve practice and reduce the risk of recurrence. Of those serious incidents that required a Coroner's Inquest, the team also support clinical staff through the process.

Key achievements in 2020/21

- Maintained all functions without interruption throughout the Covid-19 pandemic
- Established a new post Inquest and independent investigation lead to support Trust wide management of NHSE independent investigation processes.
- Rolled out human factors introductory training provided by Clinical Risk and investigations team via NTW Academy with the training available to all staff involved in the investigation and review of incidents.
- Delivered human factors training package to the Trust Board and Executive team.
- Undertook a thematic review of deaths occurring in the 3-month period post inpatient discharge with learning disseminated through a Learning and Improvement webinar.
- Agreed and implemented a process to feed CNTW information into the ICS Suicide Prevention Network real time surveillance work.
- Continued delivery of training via Medical Education for junior doctors around the serious incident process and inquests.
- Supported management of Trust wide incident process.
- Implemented use of a dashboard and mechanism for monitoring of incident sign off by responsible mangers thereby significantly improving the situation of incidents not being signed off within the expected time scale.
- Implemented a formal training package with CNTW academy to support staff and managers with the incident reporting and sign of process.

Ambitions for 2020/21

- Participation in the development of a Safer Care Work plan derived from learning from incident activity.
- Review of the serious incident policy, process and its associated practice guidance in line with the anticipated introduction of the NHS England Patient Safety Incident Response Framework (PSIRF) in 2022.
- Review of reporting processes related to serious incidents into national systems following eth introduction of PSIMMS which will replace NRLS and STEIS.
- Further develop the Incident dashboard and review process for digital documentation of learning and agreed actions from all incident reviews so that information is accessible within dashboards allowing more timely thematic analysis.

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- Development of a Training Workshop aimed at providing practical skills and advice to staff when preparing for and carrying out local after action reviews, both as standalone reviews and as part of full serious incident reviews. This workshop will complement the human factors introduction training that has already been rolled out.
- To continue further joint working with the nine Northern mental health trusts in relation to mortality reviews.
- To promote the development of a family liaison post to support bereaved families.

Complaint and Claim Management

Information on how to raise a concern or make a complaint is available to patients via the Trust website, 'Have Your Say' posters and leaflets. People are advised that the Trust welcomes feedback about services when then feel things have gone wrong and has a procedure in place for dealing with concerns and complaints in an open and transparent manner.

Complaints have decreased during 2020-21 with a total of 565 received during the year. This is an overall decrease of 59 complaints (9%) in comparison to 2019-20.
In 2020/21 we responded to complaints in line with agreed timescales in 84% of cases which is a 4% increase in comparison to 2019/20.

Complaint categories which have significantly increased in comparison to 2019-20 are:

- Complaints related to admissions and discharges have increased by 34%
- Complaints related to Trust admin/ policies/procedures including record management have increased by 63%

Complaint categories which have significantly decreased in comparison to 2019-20 are:-

- Complaints related to clinical treatment have decreased by 46%
- Complaints related to appointments have decreased by 22%

Of the 95 claims received during 2020-21, over 50% of claims received were ex-gratia claims which are claims for lost, stolen or damaged personal belongings of patients, visitors and staff. The claims related to clinical negligence include those where solicitors have been appointed either in relation to investigations into a potential claim or where Inquest funding has been requested where a claim is anticipated. Although both categories have increased in comparison to 2019-20, this appears to be unremarkable.

Key achievements in 2020/21

- Ensured service delivery and continuity through the challenges of a pandemic and lockdown to maintain standards of customer service and care including the provision of complaints awareness training via Teams.
- Supported a team of staff through pandemic and lockdown whilst most were working from home ensuring a regular weekly team catch up to discuss problems, issues and maximise team morale.
- Reviewed the Standard Operating Procedures for the department specific to complaint management.
- Participated in the newly formed Northern Regional Complaints Forum to solve common problems, share learning and good practice.
- Undertook a thematic review of complaints related to Covid-19 to identify any learning.

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- Attended several Claim and Litigation Teams online events and webinars providing legal updates on claims management and receiving updates on NHS Resolution developments.

Ambitions for 2021/22

- Continue with the embedding of an integrated team of complaints, incidents, claims and inquest staff to administer the core functions supporting and strengthening the processes.
- To continue to deliver training across the Trust in complaint awareness for investigating officers.
- To work with IT and Safer Care Business Support Officer to improve the quality and range of information on the complaints dashboard.

Section 2

PUBLIC HEALTH TEAM

The Public Health Team provides Infection, Prevention Control, Tissue Viability, Medical devices, Physical Health and Public Health and Lifestyle functions to support staff and patients across the trust.

Infection Prevention and Control

As a statutory requirement, the Director of Infection Prevention and Control (DIPC) is required to provide an annual report IPC Annual Report (Link Below) that includes a summary of activity, provides assurance and developments that took place during 2020/21 relating to Infection Prevention and Control. The Infection Prevention and Control team is responsible for the outline delivery of the 2020/21 Infection Prevention and Control Annual Plan. The IPC Annual Report attached as Appendix 1.

Tissue Viability

The Tissue Viability Service is currently provided by a Modern Matron / Team lead and tow Clinical Nurse Specialist. Despite the impact of Covid-19 the team have continued to provide remote and face to face Tissue Viability advice whilst maintaining all required IPC measures.

Key achievements in 2020/21

- The team undertook 918 visits and saw 242 individual clients
- Continued the roll-out of the new NHSI / NPUAP guidance introduced in late 2018. The TVN's continued to support the Trusts continued efforts to meet or exceed national pressure ulcer risk assessment time frames and reduce incidents. (We are proud to identify no avoidable Category 3 or 4 pressure ulcers within the trust for the 9th year running).
- The team have continued to offer both bespoke and topic specific wound care training across the Trust linking in with training and physical health agendas. Utilising the remote solution and TEAMS platforms, this has allowed us to provide training to newly commissioned services and newly appointed staff.
- The team are continuing the work to develop the AI / Augmented reality educational APP to support the identification, management of pressure ulcers. A working prototype is now available, and the trust is now working with the manufacturer and local ICS teams to identify 'next steps'.
- The team along with colleagues in Informatics completed the roll-out of the 'remote solution' (Microsoft Teams) to support and provide timely advice remotely around wound

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management. All wards including newly commissioned in-patient services now have access to this.

- The team piloted and has now begun to roll-out a Skin Bundle (ASSKING) which will further augment the work to reduce and eliminate all 'avoidable pressure ulcers' from the Trust.
- We are working closely with the National Wound Care Strategy Programme to identify information and approaches that take specific account of the issues relating to working with in our specialist care areas.
- The TVN's work closely with support services including dietetics, physiotherapy, occupational therapy, nursing teams and doctors to ensure that the varying needs of the client are met. We actively participate in the multi-disciplinary team approach and share information to support the client's global treatment goals. This also includes where appropriate external providers and carers.
- The team continue to support the wider 'safer care' team with local projects / health promotion projects and national campaigns such as the seasonal flu campaign.

Public Health and Health Improvement

The Public Health Team centrally coordinate aspects of physical health, public health and lifestyle in respect of health promotion and prevention. Within the team there is a physical health and wellbeing lead and two health improvement specialists. From April 2020 and into 2021 the lead and the two health improvement specialists were redeployed to support the COVID response within CNTW.

The team provides guidance and support on public health supporting the clinical teams to embed preventative methods and lead on the implementation of public health interventions. The team also support the physical health agenda as agreed via the Trust physical health and wellbeing group. CNTW contributes to the regional training scheme for public health registrars and at least one registrar is usually attached to the team.

Key achievements in 2020/21

- Deteriorating patient work in relation to COVID-19.
- Implemented Smoke Free Trusts in Cumbria in Sept 20 (delayed due to Covid 19).
- Supported the implementation of the Local Smoking Cessation pilots within Northumberland and North CTT's.
- A Weight of Your Mind (AWOYM) Presented at National PHE summit in February 2020 and to National Local Authority and PHE webinar in June 2021.
- Passport to My Health piloted in older persons services now being rolled out across the wider trust.
- Supported the Trust wide Covid 19 testing rollout, providing leadership and redeployed of PHW lead and health improvement specialist to testing team.
- NG tube task & finish group set up to respond to the HSIB report, trust wide changes implemented in response to this. Ongoing work in relation to training continues.

Ambitions for 2020/21

- Lead AWOYM steering group to the next phase, implementation complete – Embed within clinical practice, move to business as usual. Summer challenge and relaunch.

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- Progress the AWOYM physical activity pathways workshops which were delayed due to Covid 19.
- Cancer screening:
- Roll out the pilot work from NGH bowel screening.
- Progress the work with NHSE and national screening programme leads to increase engagement with CNTW service users.
- Support the implementation of the Smoke Cessation pilots within Newcastle, and Sunderland. Move towards this model being standard practice.
- Support work to ensure the physical health monitoring form and foundation skills training are aligned with CQUIN and contracting arrangements for 20/21.
- Review the physical health strategy and ensure inclusion re health inequalities, public health & parity of esteem.
- Roll out of cascade MECC awareness training within clinical teams.
- Implement the LTP Inpatient tobacco dependency treatment service for all inpatients in CNTW with roll out commencing early 2022.
- Epilepsy task and finish group initiated to review trust wide concerns relating to epilepsy. To include writing a seizure management policy, reviewing training, and writing pathways.
- Audit of NG tube insertion and use in relation to the NG Policy in relevant clinical areas to start mid 2021.
- Development of appropriate training in Sexual health for clinical staff and updating of RIO Physical Health form to reflect this.
- Dental health training for clinical staff to be developed and rolled out.
- AliveKor pilot of mobile ECG machines for monitoring prior to prescribing antipsychotics.
- BBV screening to be carried out onsite at Plummer court as part of partnership working with NUTH.

Section 3

SAFEGUARDING AND PUBLIC PROTECTION TEAM

As a statutory requirement, the Trust is required to provide an annual Safeguarding Annual Report. This report gives an account of the safeguarding activity across Cumbria, Northumberland Tyne and Wear NHS Foundation Trust. The report covers the period April 2020 – March 2021. The report demonstrates the organisations commitment to protecting children, young people and adults at risk of harm across all service areas. The Safeguarding Annual Report attached as Appendix 2.

Section 4

NURSING DEVELOPMENT, EDUCATION AND CLINICAL QUALITY IMPROVEMENT TEAM

Professional Nursing Team

During 2020 we have supported CNTW response to the COVID-19 pandemic and the work of Gold Command. This has meant working in new ways and taking on new roles whilst maintaining where possible business as usual and this is reflected in this report. This has been an unprecedented year which has strengthened our ability to work cohesively as a team and react quickly and efficiently in our response.

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Supporting Gold Command

Senior Nurses within the Directorate have supported Gold Command since April 2020.

- Developing risk assessment and screening tools and internal track and trace processes.
- Supporting outbreak management.
- Delivering training on use of close contact risk assessment for operational managers.
- During this period, we have undertaken 3225 risk assessments, supporting staff and their households in isolation.
- In addition, we have supported the Practice Education Team and our HEI partners to deploy over 200 student nurses to support services in line with NMC emergency standards. This enabled 3rd year students to complete their programmes on time and for 1st year students provided clinical experience through our flexi pools.
- Staffing Solutions team with coordination and delivery of 1 to 1 conversation supporting staff to organise COVID-19 19 vaccination appointments
- Practice Education Team members have supported CNTW testing teams across the organisation in the testing of staff.
- We have developed and implemented a reporting process for all students and trainees whilst on placement. This ensures that students and trainees when symptomatic or have been in close contact are subject to our risk assessment and screening tools.
- In addition, we have provided access to all students in relation to Lateral Flow Testing and Vaccine roll out.
- During 2020 our teams have endeavoured to conduct “business as usual” ensuring we continue to deliver CNTW Nursing Strategy strategic aims.
- Ensuring we have the right staff, with the right skills, in the right place.
- Supporting positive staff experience.

Recruitment and Retention

Our Senior Nurse Recruitment and Retention Lead has continued to support.
Recruitment Processes supporting and leading on.

- Central Values Based Recruitment and Retention (VBRR), trust wide recruitment meeting.
- Staffing Solutions interview processes.
- Clinical Police Liaison Lead with interview processes supporting police officers to gain experience in mental health and learning disability services.
- Interviewees through interview preparation workshops
- Return to Practice students to gain employment.
- Securing our future registered nursing workforce through recruitment of newly qualified nurses, supporting close contact sessions prior to qualifying.
- Supporting national initiative to reduce HCSW vacancies to zero position.
- Delivery of virtual job fairs.

Retention Processes supporting and leading on.

- Workforce development team in the delivery of internal retention initiatives.
- CNTW Academy pathways both into the Trust and across bandings and specialities.
- Task and Finish groups a) developing Band 2/band 3 pathway b) review of group exercise providing reassurance of values.

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- Preceptorship through delivery of peer support events.
- CNTW Nursing Degree Apprentices with transition to Registered Nurses through one-to-one meetings.
- Supervision and support of deployed student nurses.
- Trainee Nursing Associate/Nursing Associate evaluation process.
- Supervision and pastoral support to Practice Placement Team members.

International Recruitment

The international recruitment team has been established since July 2017 and it continues to go from strength to strength. The systems and processes in place to support the work have been refined and are tailor made to each individual member of staff relocating to the UK.
During the global pandemic we have utilised Microsoft teams to establish contact with staff before their relocation to the UK. The impact on staff has been remarkable as we are able to remove so many anxieties and answer so many questions and though this have managed to retain those recruited despite a delay in their relocation to the UK.

Key achievements in 2020/21

Recruitment and Retention

- Continued achievement to relocate Registered Nurses and Medical staff during a world pandemic is testimony to the team.
- Recruitment of a second Senior Nurse: International Recruitment and Relocation Support (secondment).
- Relocation of 10 nurses to Cumbria (2 RGN and 8 RMN) with a further 3 nurses relocating to St Georges Park in May (all RMN).
- We have refined and continued to develop the information we share with both nursing and medical staff in readiness for their arrival. This includes information about professional bodies, preparation for registration and current COVID-19 19 guidance.

Preparation and Development

- The Drs Fellowship programme has been a huge success and we have been recognised on a national level of our achievements with this programme which is now a 3-year programme.
- When nurses relocate to the UK their priority is completing Objective Structured Clinical Examination (OSCE). As an organisation, we are continuing to build our knowledge base with the preparation of OSCE particularly with Mental Health Nurses. One of our strengths is that we are creative and will reach out to colleagues in other parts of the trust for help and support.
- One major challenge, which we have overcome, was access to Sunderland University OSCE stations where the nurses would see and feel the examination environment. However, we did not want to rely too much on accessing the university (due to COVID-19 restrictions) and have had to ‘think outside the box’.
- Identified member of staff who has worked at Cumbria university as a lecturer and understands OSCE, who will work with the team for one day per week at both Cumbria and St Georges Park coordinated by the Senior Nurse for International Recruitment.
- Shaping the Trust preceptorship programme using feedback from our international nurses this will support future internationally recruited staff.

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We have seen benefits of staff relocating to different parts of the Trust in the level of knowledge and understanding we are developing in respect of what is expected of not only the nurses who relocate but also the clinical teams in making this a success.
Our international recruitment model has been recognised nationally and locally by key individuals, and we have successfully secured bids recently via NHS England for international recruitment.
We remain ambitious in our forward thinking and will continue to develop and refine our model of international recruitment.

Practice Education Team (PET)

The COVID-19 pandemic has presented challenges in the continued delivery of clinical placements as this period has seen significant changes to the way in which we deliver services. With the introduction of NMC emergency standards to support NHS services we have worked in partnership with our HEI partners and clinical services to ensure we continue to meet our contractual obligations, secure our future workforce, and provide high quality clinical placement and educational opportunities.

Key achievements in 2020/21

Team Structure

- We have undertaken a review of team structures and introduced new roles.
- Team Manager.
- Educational Support Nurse.
- Practice Placement Support Coordinator.
- Advancement of the AHP agenda with a member of the PET with a specific remit and dedicated time to take this work forward Trust wide.

Placement Capacity

We have continued to expand placement capacity through supporting new and innovative ways of working.

- Implementation of a Team approach to create additional capacity through a more productive student to Practice Assessor /Practice Supervisor ratio.
- Additionally, this model advocates the use of qualified Nursing Associates for year 1 student support, and AHPs to provide practice supervision to any professional learners.
- Worked in partnership with Northumbria University to develop a virtual programme for 1st year students delivered by experienced clinicians which includes, preparation for practice, resilience training and simulation of handover and MDT for those undertaking a “staggered” placement.
- We are working with HEE and the Regional Effective Learning Environment leads work to support the national placement expansion programme, and the use of third sector placement providers.
- Development of Practice Assessors and Supervisors
- We have adapted our annual face to face Practice Assessor/Supervisor training package to an e learning package.
- Provided additional support to placement supervisors and students via Microsoft teams. Preparatory work has been undertaken with Practice Assessors and Supervisors for students moving into year 2 in recognition of the deficit in year 1 clinical placement.

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- We are collaborating with CNTW Academy to develop an internally facilitated and accredited module which will increase numbers of Practice Assessors and Supervisors across all services as part of our expansion programme.

Development and Supervision of Learners

- We have worked with our HEI partners to develop online Preparation for Practice materials.
- Established access to online Induction/ CPD both targeted at managing the pandemic and wider learning needs.
- Continued to ensure all learners accessed supervision and in addition provided access to online drop-in sessions facilitated by our Educational Support Nurses.
- Considering the necessary changes to delivery of community services we have utilised placement capacity funding and in addition invested significant Trust financial resources to funding provision of over 200 dedicated laptops for students use during clinical placement. This provides greater access to students whilst on placement.
- We recognise that this has been an anxiety provoking time and to provide reassurance in addition to access to supervision and support for nursing students we have developed a resilience training module. We are currently piloting this module with our current preceptee's and will deliver to all students per locality commencing in May. This programme will be evaluated, and outcome shared with our HEI partners.

Adapting to COVID-19 19 Restrictions

- The Trust was able to deploy over 200 Nursing and AHP undergraduates into paid placements within clinical services. This has enabled undergraduates to continue to meet the clinical components of their programmes and for final year students complete on time, enabling the Trust to maintain recruitment to our workforce. This initiative was a welcomed component in our ability to continue to deliver high quality services to those we serve.
- To support deployment, we developed guidance packs for clinical placements detailing the changes under the emergency standards we have utilised Gold Command communication systems to continue to update and inform.
- We have worked with HEI to establish a process to ensure all students are subject to a risk assessment carried out by the HEI prior to placement, where required additional occupational health assessment or advise is accessed and shared with the Trust and where appropriate we have employed supportive actions.
- Induction for trainees was mostly held via Microsoft Teams, however we have provided a half day of face-to-face sessions in COVID-19 secure trust approved rooms/buildings to answer induction/clinical queries, sign essential paperwork and undertake fit testing for FFP3 masks.
- Throughout this time all trainees continued to have regular weekly supervision with their supervisors to monitor their well-being. Mid placement reviews also provided additional pastoral support.
- The PET has supported colleagues in Gold Command with student close contact risk assessments and working together with HEIs and students to emphasise IPC good practice and personal protective behaviours.

Throughout these challenging times we have worked collaboratively with HEI and our colleagues across clinical placements, to adjust to changes required by necessity and continued to build on our existing robust relationships.

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We are proud that we have ensured all those students placed with CNTW have been able to complete their competencies and for those in the final stages of training complete and register with the NMC on time.

Section 5
STAFFING SOLUTIONS TEAM

The team have continued to coordinate, monitor, and develop a trust wide strategic approach to resource management by incorporating practical experience as well as workforce tools, carter learning and principles.

Key achievements in 2020/21

Recruitment

- In line with the limited licensing position, the team has reviewed the process for recruitment. Staffing Solutions staff now lead on bank recruitment working closely with workforce and service teams to facilitate recruitment.
- The Clinical Professional Lead is a member of the VBRR group which has enabled identification of “hot spots” and ability to work closely with services and gain robust understanding of Trust-wide strategies and opportunities.
- To further maximise efficiency, the team has made improvements to the DBS system.

Meeting Service Need

- To maximise the efficiency of the temporary staffing workforce, the team is currently working to remove bank workers who have not worked shifts in a specified period. This will also release places in terms of licensing.
- The team has continued to develop strong links with operational services, including attendance at staffing meetings, sharing shift fill rate reports, addressing any concerns, cascading of any requests for bank only workers regarding short term contracts to cover shortfalls.
- The team is currently involved in the development of a new rostering system
- An allocated member of the team now manages new starters induction, and introductory shifts.
- Work undertaken in relation to managing complaints has seen a vast improvement in the process, with reduction seen in timescales to resolve complaints for both bank and agency staff.

Communication

The team has adapted to working remotely, as appropriate
The team has worked to improve communication with bank only workers by targeting communications more effectively. This has been essential during these challenging times and some of the improvements seen have been.

- Targeted communication in relation to the ‘Flu campaign has seen uptake rise to 74.16% for 2020-2021.
- The team has improved communication regarding ongoing circulars and reminders to bank workers regarding managing their e-learning.

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Supporting Gold Command

- One to one conversation's have been undertaken with staff members to promote access to COVID-19 vaccine.
- 271 staff were contacted.
- 177 x already vaccinated from GP/other healthcare/ CNTW (or had 1st appointment booked) & relevant forms completed.
- 59 x Expression of Interest completed.
- 16 x terminated when contacted/checked working and removal letters sent
- 19 x declined.
- Undertaken close contact risk assessment for bank only staff and liaised with Agency partners to support outbreak management processes.
- The team has also undertaken COVID-19 risk assessment of bank only staff.

Developments for 20/21

- Plans to provide clinical supervision to bank only nurses are in development
- Support to develop a Trust-wide e-rostering system will continue.
- Analysis of temporary staffing activity and availability will be undertaken to support strategic staffing work streams.

Developing discussion forums for bank workers in collaboration with staff side.

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NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
6th October 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, Executive Director of Nursing

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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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

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

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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.

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

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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

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

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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 i.e. 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

IPC Dataset 2020/21

The following tables form the Infection Prevention and Control data set for 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

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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.

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**
Total	**32**	**34**	**29**	**37**	**50**	**38**	**46**	**41**	**33**	**25**	**35**	**33**	**423**

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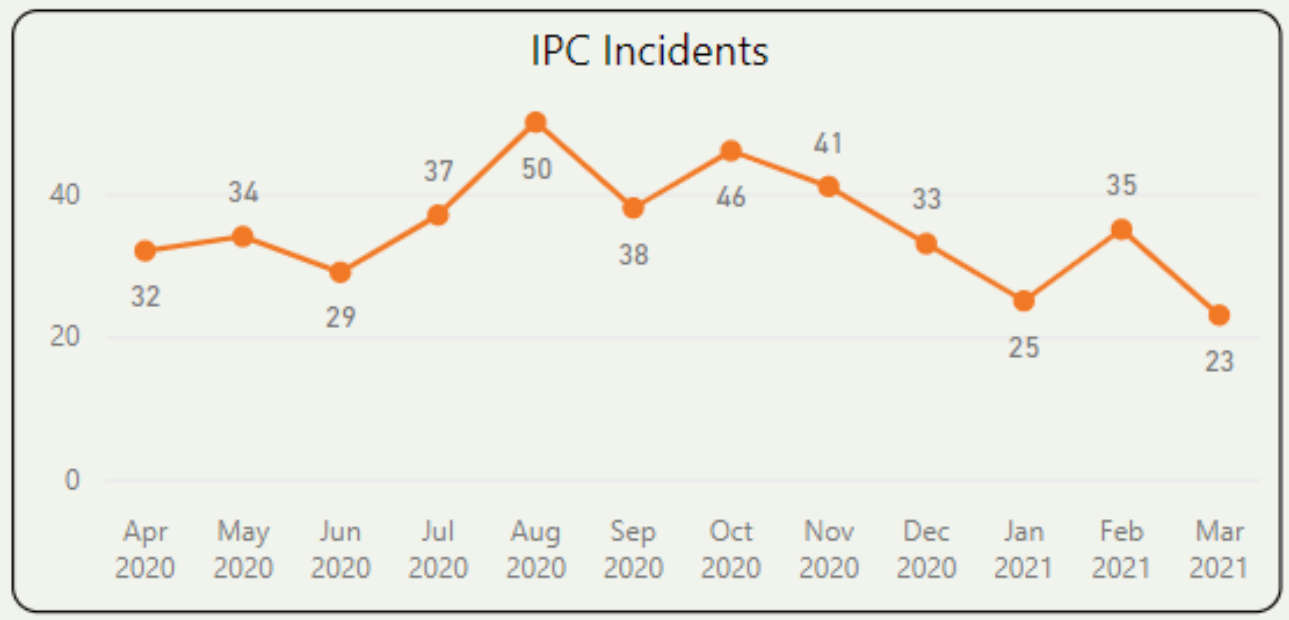

Key achievements

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 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.

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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.

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 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.

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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.

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.

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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.

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.

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- 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.

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.

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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.

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**

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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. • 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

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- 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.
- 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.

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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.

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.

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- 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.

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.

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Linen, Laundry and Dress

- All staff are required to adhere to “bare below the elbow” practice guidance note which was reviewed in 2019/20.

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- 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 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.

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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.
- 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.

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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
- 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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NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
6th October 2021

Title of report	Annual Report for Safeguarding and Public Protection 2020–2021
Report author(s)	Acting Team Manager Safeguarding and Public Protection / Named Nurse – Sheona Duffy Claire Thomas – Associate Director – Safer Care
Executive Lead (if different from above)	Rajesh Nadkarni Executive Medical Director

Strategic ambitions this paper supports (please check the appropriate box)

Work with service users and carers to provide excellent care and health and wellbeing	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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Key Points to Note:

- The Trust Safeguarding and Public Protection annual report covers the period from April 2020 to March 2021.

- Safeguarding is fundamental to all work of the trust. This report provides assurance that the trust is fulfilling its statutory safeguarding responsibilities and demonstrates a strong commitment to working together within all aspects of safeguarding and public protection.

- Safeguarding and public protection activity remains constant with cases identified across the Trust having high levels of vulnerability and complexity. We have been mindful that the pandemic has also increased vulnerabilities and hidden harms for our service users, for example increase in Domestic Violence on national level.

- The trust has exceeded its training target percentage set by NHS England of staff trained in Prevent.

- Embedding signs of safety (SOS) to ensure that children's safeguarding is bespoke to the needs of that child and capturing their individual voice, and a strengths-based approach to safeguarding has been a priority for local partners. The multi-agency training provided by partners has been cascaded to the four localities and the safeguarding practitioners.

- Throughout the pandemic CNTW has engaged with each safeguarding board to provide assurance that we continued to provide safe care and treatment for our service users.

- Throughout the pandemic safeguarding training has been available through eLearning systems and virtual training events. NHSE has continued to provide via Bond Solon specialist safeguarding training.

- The report outlines the progress that has been made in safeguarding the health and wellbeing of patients and carers. It highlights areas where the safeguarding and public protection team are continuing to develop and offers an insight into the safeguarding priorities for the organisation.

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Safeguarding and Public Protection Annual Report 2020/2021

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Introduction

This annual report gives an account of the safeguarding activity across Cumbria, Northumberland Tyne and Wear NHS Foundation Trust. The report covers the period April 2020 – March 2021. It demonstrates the organisations commitment to protecting children, young people and adults at risk of harm across all service areas.

Safeguarding activity across the Trust continues to increase in volume and complexity. Safeguarding concerns are positively being recognised more frequently across clinical areas. All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults at risk and to assure themselves, regulators and their commissioners that these are working. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor and a Named Nurse.

Ultimately the Trust Board requires assurance that the organisation is fulfilling its obligations to safeguard and promote the welfare of children and vulnerable adults. Throughout this reporting period, we have faced unprecedented times of an international pandemic, however we have continued to deliver upon the safeguarding agenda.

"Safeguarding is everybody's business"

Safeguarding and Public Protection Team

The Safeguarding and Public Protection service consists of a Team Manager/ Named Nurse, six Senior Nurse Practitioners, Case Review Report Writer, two MASH post, Safeguarding and Public Protection Development Officer and the Police Liaison Nurse who bring a variety of safeguarding and public protection expertise, skills and experience. They are supported by the Safer Care Administration Team.

The core functions of the team are:

- To provide clinical leadership in respect of safeguarding to support high quality safeguarding and public protection practice for children and adults.
- To provide a "triage" service for all safeguarding and public protection concerns raised within the organisation to ensure the individual is safeguarded and effective safety plans are in place.
- Sharing learning from internal and external reviews of cases and best practice.
- To provide support and advice on complex cases.
- To attend MARAC (Domestic Abuse meetings), MAPPA and Prevent (public protection) multi-agency meetings on behalf of the trust.
- Provide strategic advice and leadership through the involvement in Safeguarding Practice Reviews, Safeguarding Adult Reviews and Learning Lesson Reviews.

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- To provide challenge and scrutiny of safeguarding and public protection practice including the interface with statutory agencies.

- To provide oversight and development of policy and procedures.

- To provide strategic vision in respect of safeguarding and public protection.

- To provide high quality supervision and check that supervision delivered across the organisation is in line with evidenced based practice.

- To support individuals working with adults at risk to practice in adherence to the six safeguarding principles.

The Safeguarding and Public Protection Team aims to support all trust staff to keep children, young people and adults at risk, safe and to meet statutory obligations. We promote collective accountability in all that we do, working together to prevent all forms of abuse or neglect.

A commitment to safeguarding children and adults is evident at all levels within the organisation. The Trust has a clear and consistent structure in place to ensure scrutiny and challenge of safeguarding arrangements and consideration of the impact on the people who use services.

Key achievements 2020/2021

- ✓ Contributed to the development of each localities strategic safeguarding agenda.

- ✓ Created a strong and productive working relationship with Cumbria safeguarding board.

- ✓ Reviewed and stopped the MARE process in North Cumbria and brought community risk management in line with national standards.

- ✓ We continued to work with prioritising the PREVENT agenda.

- ✓ Embedded two new posts in the Sunderland and Northumberland Multi Agency Safeguarding Hub (MASH) posts within the team. Northumberland as a substantive post and Sunderland continues to be on non re occurring funds.

- ✓ Throughout the pandemic we have delivered a full uninterrupted SAPP service.

Operational Management Developments

- Closer working relationships with the locality groups - SAPP practitioners now attend locality safety meetings to facilitate sharing of learning and improved communication.

- MASH in two localities has been strengthened by the development of two dedicated

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posts to sit within the MASH. These posts will ensure that vulnerable people with mental health and learning disabilities will get the correct service at the right time from the right professional.

- We have supported the opening of Acklam Road Hospital and Lotus ward, in the context of re commissioning of regional specialist inpatient beds for young people.

- We have maintained strong multi-agency cooperation to Counter terrorism Policing (Special branch) and local authority Channel panel chairs within Cumbria and Northumbria Police area and the 7 CCG's that CNTW covers.

Safeguarding Assurance

The Safeguarding and Public Protection Group is a quarterly Trust Subgroup of the Trust Quality & Performance group. It is a governance and assurance group that support learning and practice development in safeguarding across Trust services and staff. The Safeguarding Group is chaired by Group Nurse Director Safer Care who brings challenge and scrutiny into the work of the group.

Through the pandemic in response to Trust business continuity planning meetings were stood down to ensure that delivery of front-line services. However internal trust assurance and reporting was provided through other forums:

- BDG Safety - weekly meetings – discussion of significant/complex safeguarding concerns.
- CDTQ Monthly Safer Care reports.
- Bi-monthly Trust Board reports for Case reviews.
- Quality and Performance Committee Quarterly Safer Care reports.
- Locality Care Groups Quality and Performance reports include a SAPP activity report.
- CCG quarterly Safeguarding Dashboard reports.

Safeguarding and Public Protection Data

There has been a significant increase (+12.9%) in Safeguarding and Public Protection concerns reported into the SAPP team during 2020/21 where 11326 incident reports were completed, compared with 100036 in 2019/20. The SAPP Practitioners review each report, liaising with services and recording on service user health records and the safeguard system.

This increase in safeguarding and public protection concerns is multi-faceted including a greater awareness of staff in recognising vulnerabilities through training; societal changes and increased deprivation; changes to early help and available support leading to greater unmet needs of children and families and an increase in prevalence of children and young people's mental health. A high level of domestic abuse incidents are evident across the localities we serve.

During 2020/21 all local authority areas hold a weekly MARAC, reflective of the expected increase in domestic abuse during the pandemic. There has been an additional 100 incidents of domestic abuse affecting CNTW service users.

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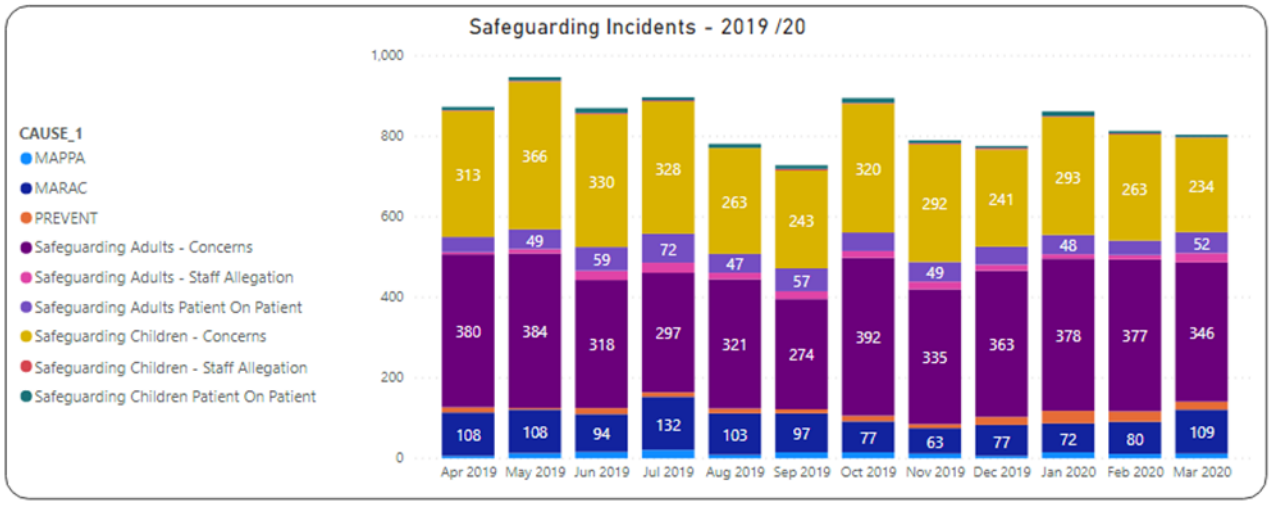
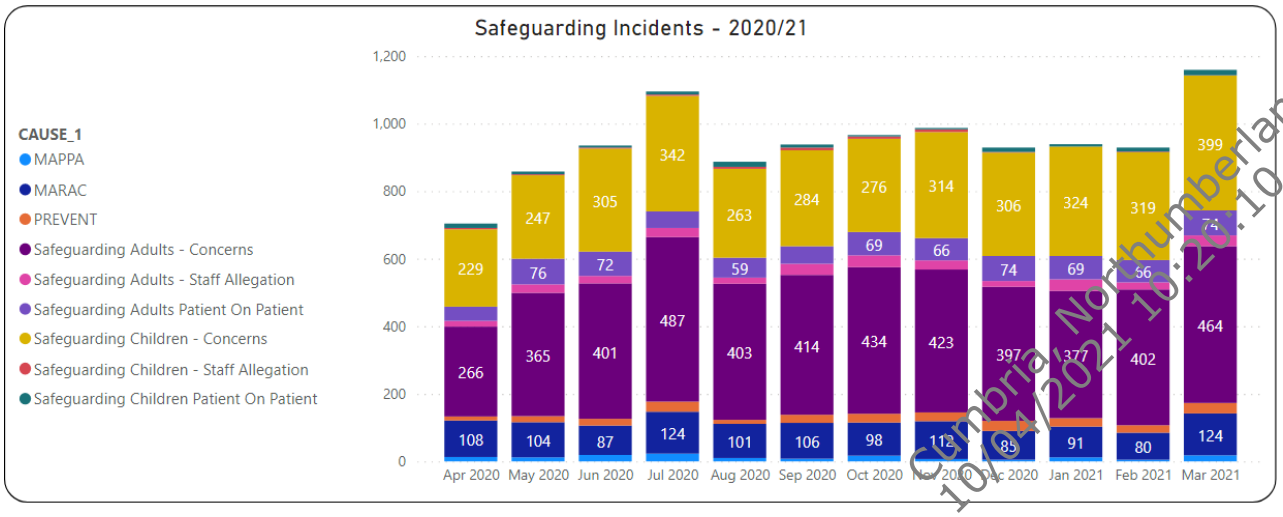
There has been a significant increase in the volume of referrals across the seven local authority areas. All referrals require information from CNTW to ensure a thorough assessment to be carried out and to enable appropriate support and safeguarding for individuals who are often extremely vulnerable.

Emotional harm continues to be the most reported type of abuse and includes the impact of parental mental health on children.

The SAPP team are receiving increased reports of young people and adults attending services with poor mental health and using substances and self-harm as a way to cope with this. This is being seen by other agencies such as police and social care.

Staff reports of patient-on-patient incidents have also increased which is reflective of the reported increased acuity seen by in patient staff.





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Safeguarding & Public Protection

CAUSE_1	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
Safeguarding Adults - Concerns	380	384	318	297	321	274	392	335	363	378	377	346	**4165**
Safeguarding Children - Concerns	313	366	330	328	263	243	320	292	241	293	263	234	**3486**
MARAC	108	108	94	132	103	97	77	63	77	72	80	109	**1120**
Safeguarding Adults Patient On Patient	38	49	59	72	47	57	46	49	45	48	36	52	**598**
Safeguarding Adults - Staff Allegation	5	11	23	25	16	19	17	19	15	11	11	23	**195**
PREVENT	13	4	15	11	12	10	14	10	20	31	26	20	**186**
MAPPA	6	13	16	21	9	15	15	12	6	15	11	12	**151**
Safeguarding Children Patient On Patient	8	9	12	8	10	9	12	7	5	12	6	6	**104**
Safeguarding Children - Staff Allegation	2	3	3	3		4	2	3	4	2	3	2	**31**
Total	**873**	**947**	**870**	**897**	**781**	**728**	**895**	**790**	**776**	**862**	**813**	**804**	**10036**

Safeguarding & Public Protection

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
Safeguarding Adults - Concerns	266	365	401	487	403	414	434	423	397	377	402	464	**4833**
Safeguarding Children - Concerns	229	247	305	342	263	284	276	314	306	324	319	399	**3608**
MARAC	108	104	87	124	101	106	98	112	85	91	80	124	**1220**
Safeguarding Adults Patient On Patient	42	76	72	49	59	52	69	66	74	69	66	74	**768**
Safeguarding Adults - Staff Allegation	17	25	22	27	18	33	35	27	17	34	21	32	**308**
PREVENT	12	18	20	30	12	24	26	26	30	25	22	31	**276**
MAPPA	13	12	19	23	10	8	17	7	5	12	5	18	**149**
Safeguarding Children Patient On Patient	13	8	6	9	15	9	4	4	13	7	12	16	**116**
Safeguarding Children - Staff Allegation	4	3	3	4	6	8	7	8	2		2	1	**48**
Total	**704**	**858**	**935**	**1095**	**887**	**938**	**966**	**987**	**929**	**939**	**929**	**1159**	**11326**

Our Commitment to Partnership Working

The safeguarding and public protection team continue work with all partner agencies and will contribute to multi agency safeguarding arrangements to ensure robust safety plans are in place. The Locality Care Groups and SAPP team work together to ensure there is appropriate representation at Safeguarding Partnership meetings, boards, and subgroups.

Clinical Police Liaison Lead (CPLL)

The Clinical Police Liaison Lead is an established role within the trust for 7 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.

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, working closely with Police colleagues around training, a gap analysis they have completed and 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. Links with British Transport Police remain and have expanded to cover the new areas also. The role has proven key during pandemic in being central point too share out and responds to developing need due to covid, ensuring support for police colleagues and our services around all matters required.

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.

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Training and education off new student officers have 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.

Police and Partner meetings have been stood down mostly during this time, but there still have been good and clear communication between Police and teams with support of the CPLL, and developments occurred where needed. There has been lots of work around developing unique joint plans to ensure all agencies involved with a person are aware from that person also of the best way to respond when in distress/crisis. This has been helpful particularly during lockdown and throughout the pandemic.

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 meetings has increased and often cannot get to all invited, so advice, information, or SAPP colleagues attend with Police where indicated.

Prevent

The CNTW SAPP Prevent role continues to be an instrumental aspect of the management of both the mental health and vulnerability factors with individuals who have been referred to Prevent. In 2020/21 referrals to Counter Terrorism Policing from CNTW were second only in number to those received from educational establishments.

Through the support afforded by the SAPP Prevent lead role it is clear that members of CNTW understand the key role safeguarding plays in Prevent and the requirement for early intervention, ensuring those vulnerable do not enter the criminal space.

Statistically it is apparent there has been a significant increase in the number of referrals, information sharing requests and attendances at Channel panels across the seven local authority areas. This increase equates to 48% over the period 2019-2020 and 2020-2021. That workload shows little sign of abating in the first quarter of this year.

It should be noted that every information sharing request from Counter Terrorism Police/Channel panel requires information from the SAPP Prevent lead for a thorough assessment to be carried out and to enable appropriate support and safeguarding for individuals who are often extremely vulnerable. Unlike other areas of SAPP work, such as MARAC or MAPPA, a case may have many contacts and discussions with partner agencies

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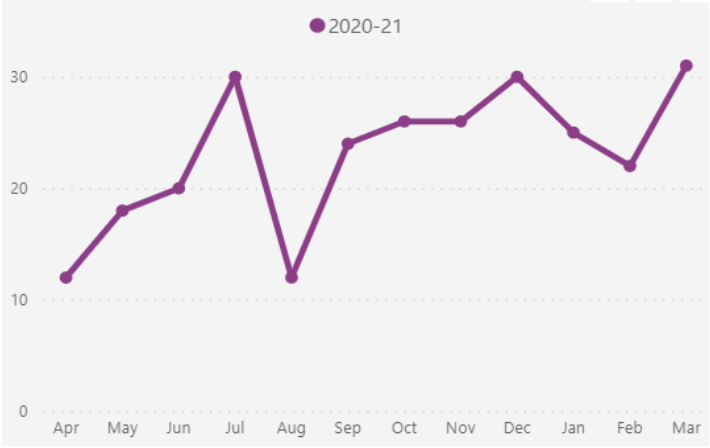
during the period a case is active. For example, one client in Northumberland who has been open to our services has been discussed in the Channel panel for the last 18 months.

Finally, the last 12 months have seen 4 individuals known to CNTW convicted of terrorism offences. It is expected that when these individuals near release from prison they will be managed at MAPPA level 3. Attendance at such meetings also form part of the SAPP Prevent lead's role.

Prevent Referrals 2020-21



External Assurance Audits

There have been no formal external audits during this year due to the pandemic response. However, we have continued to provide data and assurance where required and have completed internal CNTW audits for safeguarding adults and MARAC compliance.

Quality Assurance Framework (QAF) audits

The Trust also completes annual Quality Assurance Framework Audits in relation to their duties under the Care Act 2014 for safeguarding adults. This tool aims to assess the effectiveness of the arrangements for safeguarding adults at a strategic level. Assurance has been provided to the LSAB's that the trust is meeting its safeguarding adult responsibilities. A trust Director attended a challenge event in one locality. This promoted constructive challenge to trust safeguarding arrangements and provided assurance that the trust is meeting its safeguarding responsibilities.

External Inspections

Several OFSTED and CQC inspections have taken place within Local Authorities/health that the trust has supported with case information and attendance at focus groups and case scrutiny for the inspections.

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Raising Awareness
The trust communications team have supported Safeguarding and Public Protection through a range of information to staff this has included:

- Seven-minute briefings
- Safe Sleeping
- Domestic Violence for patients and staff (covid related)
- Learning from Case Reviews
- Prevent in line with national intelligence

The team also ensure any learning identified and any safeguarding campaigns/awareness raising information are available to all staff trust wide via the Safer Care Intranet page.

Training
The Trust has maintained compliance above the 85% set training target for the year for Safeguarding and Public Protection. Prevent training has exceeded the 90% target set by NHS England. Training requirements have been updated in line with the intercollegiate document. Level 3 face to face training for all professionally registered staff was placed on hold due to pandemic and we are now below target for this training.

Policies and Procedures
Safeguarding policies are in place and are accessible to staff via the Trust intranet. The seven Local Authority areas safeguarding, and public protection policies and procedures are also available via links on the staff intranet site. During the reporting period, SAPP policies are continually monitored and updated in line with local and national changes.

Case Reviews
The trust has continued to participate in statuary and non-statutory reviews

- Local Children Safeguarding Practice Reviews- (LCSPR)
- Safeguarding Adult Reviews (SAR)
- Domestic Homicide Reviews (DHR)
- MAPPA Serious Case Reviews (SCR)
- Appreciative Inquiries (adults and children multi agency reviews)

Over the last twelve months there has been 6 LCSPR, 5 SAR and 4 DHR commissioned where CNTW have been involved with the family.

All reviews are reported to the Trust Board on a bi-monthly basis and lessons learnt are cascaded throughout the organisation and/or built into future training. Bespoke training has also been provided for those service areas involved to ensure all staff have received the lessons learned.

The key areas of focus are outlined below. The areas of focussed learning have been shared via the Trust wide safer care bulletin and attending the locality safety meetings.

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- Safeguarding Children - Clinician's responsibilities to attend child protection meetings and our strategy responsibility to engage. We have updated the policy guidance provided to staff.

- Domestic Abuse - recognising and responding to domestic abuse, completion of MARAC check list and referrals and completing as standard on core documentation, risks in relation to domestic abuse.

- Public Protection - Concern expressed from carers should be taken very seriously and information used to assess risk to others.

- Safeguarding adults - The link between substance misuse, mental health and recognising and responding to self - neglect.

Annual Work Plan 2021/22

All the actions from the 19/20 Annual Work plan have been achieved.

The workplan for the SAPP team includes:

- Evaluation of the newly appointed CNTW MASH Practitioners and potential development of these posts within other localities if funding is available.

- Review and development of CNTW support to Prevent with local and national partners.

- Embedding local and national safeguarding priorities in our teams and services across CNTW including:

    - Transitional safeguarding
    - Signs of safety
    - Contextual safeguarding
    - The new Domestic violence bill

- Improving the data monitoring and quality assurance reporting of safeguarding data internally and to local partners.

- Reviewing Trust systems for learning lessons from safeguarding incidents that have occurred internally and externally to ensure that learning is shared and embedded.

- The Clinical Police Lead will continue to work closely with Cumbria Police to further enhance close working relationships with support of any new developments in conjunction with the Safeguarding Development Officer.

- The Clinical Police Liaison lead is continuing to look at data and doing more around Police activity data, to evidence what we do and how we do it, as well as look at demand and ensure capturing lessons learnt. Working with the Safer Care Business Manager a police activity dashboard is being developed to give us clearer and better understanding.

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Conclusion

This annual report provides the Trust Board, partners and stakeholders with an overview and assurance of the activity for Safeguarding and Public Protection during the periods 2020/21, including the learning from Case Reviews and investigations. The Safeguarding and Public Protection Team will be working with locality teams to ensure the learning is embedded in practice. The last 12 months have been unprecedented, the CNTWSAPP team have provided a reliable, consistent quality services ensuring that our staff and patients were safe.

The Team are looking forward to the year ahead in ensuring safeguarding and public protection is maintained as a high priority for the Trust and continues to be viewed as everyone's business.

Appendix 1 – Definitions

Local Child Safeguarding Practice Reviews (Previous Serious Case Review)

Serious child safeguarding cases are those in which:

- Abuse or neglect of a child is known or suspected; and
- The child has died or been seriously harmed.

The criteria which the local safeguarding partners must take into account when determining whether to carry out a local child safeguarding practice review includes whether the case highlights or may highlight:

- Improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
- Recurrent themes in the safeguarding and promotion of the welfare of children;
- Concerns regarding two or more organisations or agencies failing to work together effectively to safeguard and promote the welfare of children;
- Or is a case which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

Safeguarding partners should also have regard to the following circumstances:

- Where they have cause for concern about the actions of a single agency;
- There has been no agency involvement with the child / family prior to the incident and this causes for concern;
- More than one local authority, police force area or clinical commissioning group is involved, including in cases where families have moved around;

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- The case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings (this includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005).

Some cases may not meet the definition of a 'serious child safeguarding case' but the safeguarding partners may choose to undertake a local child safeguarding practice review because they raise issues of importance to the local area, for example good practice, poor practice or where there have been 'near miss' events.

Safeguarding Adults Reviews - SAR
(1) An Safeguarding Adult Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

Condition 1 or 2 is met.

(2) Condition 1 is met if:
(a) The adult has died, and

(b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if:
(a) The adult is still alive, and
(b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to -
(a) Identifying the lessons to be learnt from the adult's case, and
(b) Applying those lessons to future cases.

Care Act 2014.

Domestic Homicide Review – (DHR)
The guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act) 1

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The Act states:

(1) In this section “domestic homicide review” means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016

MAPPA - SCR

The SMB (Strategic Management Board) must commission a MAPPA SCR if both of the following conditions apply.

The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed.

The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

The purpose of the MAPPA SCR is to examine whether the MAPP arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to effectively manage the risk of further offending in the community.

MAPPA Guidance 2012 (updated 2019) Ministry of Justice.

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Report to the Board of Directors
6 October 2021

Title of report	**Health Education England NE and NC Annual Quality Report 2021**
Report author(s)	**Report written by Prof Namita Kumar and Mr Pete Blakeman, HEE NE PG Dean and Deputy Dean Presented/shared to Board by Dr Bruce Owen, DME**
Executive Lead (if different from above)	**Dr Rajesh Nadkarni**

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

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

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

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability	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

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Health Education England North East & North Cumbria

Annual Quality Report 2021

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

Final Report – August 2021

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1 Background to this Annual Report

The 2021 Health Education England North East & North Cumbria (HEE NENC) Annual report provides a 'year-end' summary of the education and training currently provided by the named Local Education Provider (LEP). It is intended to promote a board level overview of the training related strengths and weaknesses of the LEP, together with priority areas for action and associated HEE NENC offers of support. Detail supporting this report is contained in each LEPs own Self-Assessment Report and the ongoing LEP Quality Improvement Plan. The HEE priorities identified this year are to be reported on over the 2021/22 training cycle in order to inform the next Annual Dean's Quality Meeting (ADQM) in 2022.

HEE NENC's role in Quality Management and Assurance of the Clinical Learning Environment

HEE NENC is responsible for monitoring and providing onward assurance to HEE, the professional regulators and the wider NHS regarding the quality of the clinical learning environment for all training placements. The Postgraduate Dean has overall responsibility for Quality. The required standards are contained in the six themes of the HEE Quality Framework and the associated escalations of the HEE Intensive Support Framework and, for medical training programmes, in the GMC Standards for Training (Promoting Excellence). HEE NENC works with and provides support to each LEP throughout the training cycle and provides significant amounts of funding to each organisation through the NHS Education Contract to support training placements, resources and facilities and trainers and educators.

HEE NENC gains assurance through the scheduled programme-led monitoring of training placements including Quality Reporting, Visits, and Meetings, and through triangulation of the data and information it shares with and receives from programmes managed at a regional or national level (e.g. Libraries, Pharmacy, Healthcare Science), other organisations including HEIs, other NHS Arm's Length Bodies and Regulators. Where concerns arise, HEE NENC uses its escalation processes to describe and monitor its concerns, the level at which it is having to work with an individual organisation, department, programme or the wider system to ensure the appropriate steps are taken to clarify, improve and resolve the concerns raised.

When there are concerns that a LEP is failing to meet the required HEE or regulator standards, (either as a whole organisation, in individual training departments, or when there is system-wide concern raised about an organisation), HEE NE works directly with the wider NHS via Quality Surveillance Groups, Improvement Boards and Risk Summits to collectively discuss the issues of concern, confirm plans for improvement with the LEP and to agree measures of success with a realistic timeframe for these to be achieved.

HEE NENC is always keen to provide support in order to improve training in all locations. Should programme-level actions fail to resolve issues then the relevant HEE NE Deputy Postgraduate Deans/Directors (Foundation, Specialty, GP, Dental, Quality and Revalidation) together with the Postgraduate Dean, are available for consultation, advice and further actions as deemed necessary; all will work with the LEP at Director and Board Level to help resolve issues and concerns.

The statutory responsibilities of the Postgraduate Dean

Please note that the Postgraduate Dean is the Responsible Officer (RO) for ALL doctors in training in approved training placements. The Postgraduate Dean has statutory accountability to the General Medical Council for both assuring quality of training placements for ongoing approval, and for the revalidation of individual doctors in training. Should revalidation or fitness to practice concerns arise concerning any doctor in training then, as the doctor's RO, the Postgraduate Dean must be informed and be involved in the decision-making processes. For ALL doctors in training the Lead Employer Trust must also be informed in its role as the doctor's employer

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2 Executive Summary and HEE NENC statement of Assurance

HEE NENC Annual Assurance Statement on overall quality of training & education provision

HEE NENC acknowledge the challenges that have faced the NHS since 2020 and the impact that Covid-19 has had and continues to have on clinical services and on education and training. Despite this, we would like to thank the Trust for excellent engagement and a continued effort to support the regions learners during a difficult and challenging time.

Whilst the 2020/21 training cycle provided less training related data than usual due to the pandemic, HEE NENC is pleased to note that the Trust continues to receive good feedback from learners and has provided excellent support over the last 12 months.

HEE NENC were particularly impressed at the Annual Dean's Quality Meeting with the trusts support to establishing training posts in primary care, the maintenance of pharmacy posts and the regional collaboration with local acute trusts partners in delivering education and training.

Several areas of notable practice were noted at the Annual Dean's Quality Meeting including:

- The ongoing collaborative work with Higher Education Institutes to target recruitment and increase placement capacity.
- The substantial support provided, and excellent feedback received from the 200 nursing students re-deployed into the trust during the pandemic.
- The work of the Trust's Training Academy who successfully moved education to an on-line format.
- The psychological support made available across both trust and ICS, which included provision of wobble rooms, a single point of contact for supportive resources and weekly access to the Trusts Executive for question-and-answer sessions.

We will be encouraging all Trusts as part of self-assessment 2021/22 to share good practice via the good practice app and also submit posters for the planned Spring 2022 HEE NE Quality and Patient Safety Conference. Details for the conference will be shared in the next few months.

A summary of overall HEE ISF escalation levels for the Trust is provided in the grid below and more detail for specific domains and training placements is contained in the HEE NE Quality Reporting Documents including the Trust's Self-Assessment Report (SAR) and the Quality Improvement Plan (QIP). **The full HEE NE grid of our end of year view can be found in appendix 1.**

HEE NE and NC Summary View of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust							
Initial Education Contract (LDA) HEE NE Funding 2020/21: £7,447,710							
Current HEE Intensive Support Framework Escalation Levels							
	Overall	Domain 1 Learning Environment & Culture	Domain 2 Educational Governance & Leadership	Domain 3 Supporting & Empowering Learners	Domain 4 Supporting & Empowering Educators	Domain 5 Delivering Curricula & Assessments	Domain 6 Developing a Sustainable Workforce
HEE ISF LEVEL	0	0	1 Governance of system & post changes	0*	0*	0	0
HEE Intensive Support Framework Levels (KEY)		0* No escalated concerns with sustained excellent feedback (programme level management)		0 No escalated concerns (programme level management)		1 Identified concerns managed at Deans Executive Level (DEMQ led management)	
		2 Further escalation of concerns shared at system level e.g. local QSG and professional regulators		3 Further escalation of concerns with high risk of training suspension & regulator enhanced monitoring		4 Training Suspended and/or posts withdrawn	

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Summary of training provision by exception

Areas of sustained high-level training provision

Sustained high level performance in training provision is noted in the following areas:

- Year on year ranking in trainee NTS
- Year on year ranking in trainer NTS

Escalated/Continuing training concerns requiring action in 2021-22 Training Cycle

Concern regarding the performance of training provision has been noted in the following areas:

- Governance of system & post changes

Emerging or recurrent training concerns requiring further triangulation/action in 2021-22

Given the reduced amount of data during 2020, HEE NENC will triangulate the following summary from 2019 – with new data in 2021. These were areas of potential concern that were identified as requiring further triangulation in 2019 and which will be reviewed with new data this year.

- None

Emerging workforce concerns identified as potentially impacting on training placements/programmes

The following programmes and placements have been identified as being affected by issues within the Trust's own workforce SAR declaration (i.e., NOT numbers of trainees/placements) and thereby at risk of being unable to deliver the relevant curricula if not addressed.

- Psychotherapy – Core psychiatry training programme.
- Trainer capacity in N Cumbria – Core psychiatry training

Specific actions required from Trust in 2021-22 Quality Reporting Cycle

1. To report in 2021-22 SAR on the HEE NE overarching priorities for training provision outlined in this Annual Report

2. To provide updates on all areas noted above in 2021-22 Self-Assessment Report and Quality Improvement Plan and to work with HEE NE Programmes, Directors, and Dean as necessary to resolve any escalated or emerging issues of concern.

3. To review new data across the 2021/22 training cycle to help triangulate and identify areas of good practice or potential issues, and for these to be integrated with the 2021/22 training self assessment document templates.

4. To keep HEE NE informed of any potential changes in Trust configuration in order to minimise impact on training placements and to prevent potential withdrawal of training approval.

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3 HEE NE overarching priorities for all LEPs to report on in 2021-22 Training Cycle

As well as being responsible for the monitoring and onward quality assurance of the clinical learning environment in all LEP placements, HEE NE promotes system-wide sharing of best practice and has identified priority areas for the 2021-22 training cycle. These are listed in outline below and link directly to the themes of the HEE Quality Framework. The priority areas will be a feature in the 2021/22 Self-Assessment Report which will include more specific questions to be reported on. Trusts can anticipate that these priority items will be included in the agenda of their 2022 Annual Dean's Quality Meeting.

Domain 1 – Learning Environment & Culture

- We will wish to explore the impact of Covid-19 on the clinical learning environment and in particular on teamworking and mutual support.
- Equality, Diversity and Inclusion strategies and initiatives are a priority for both HEE and the regulators in all aspects of training - we will be seeking specific information regarding your organisation's strategies.

Domain 2 – Educational Governance & Leadership

- Learners have identified difficulties both in raising concerns about training and patient safety and also in receiving timely feedback when they have reported a particular issue. We will be seeking details about your organisations policies and processes in this regard.
- HEE's new 2021 Education Contract sets a new framework for financial governance with LEPs and we will be exploring how you manage this in more detail in particular how resources allocated within the education contract have been used to provide specific support to all trainers and educators.

Domain 3 – Supporting & Empowering Learners

- Facilities provided to trainees and learners have been identified as a potential need and we will be seeking details about specific resources and initiatives you have in place.
- We would like to capture the health and wellbeing initiatives you have in place for trainees and learners.

Domain 4 – Supporting & Empowering Educators

- We will be seeking information about how you continue to support trainers and educators in their roles especially given the pressures the pandemic has placed on their work time and ability to take on/continue in additional roles.
- We would like to capture the health and wellbeing initiatives you have in place for all Trust staff.

Domain 5 – Delivering Curricula & Assessments

- All training has been affected by the pandemic to varying degrees. We will be exploring specific strategies you are using to ensure curriculum delivery and recovery of training shortfall is provided.
- Clinical service recovery is a priority for the NHS and we will explore how your plans for this include prioritisation of education and training.

Domain 6 – Developing a Sustainable Workforce

- We will once again ask you to identify which areas of workforce for service and training you feel are vulnerable or where you wish to expand.
- The new ICS will have a workforce plan and we will wish to explore how you intend to work with us to plan for the long term needs of the North East and North Cumbria.

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4 2021-22 Quality Cycle – Reporting Timeline and Significant Events

To facilitate planning of quality reporting and meetings in 2021-22, the table below summarises key dates and events from August 2021 onwards. Please note that the HEE NE Quality Team can always be contacted via Quality.NE@hee.nhs.uk

Analysis of 2021 GMC NTS Trainee & Trainer Surveys	August 2021
HEE NENC to send 2021/22 Annual Report Documents (SAR/QIP) and updated Guidance to LEPs	September 2021
Trusts to submit updated QIP to the Quality Team	30 September 2021
Quality Team offer of support engagement meetings to Trusts	October - December 2021
National Education and Training Survey (NETS) open	November 2021
Trusts to return completed 2021/22 Annual Report (SAR/QIP/Unit reports) to the Quality Team	31 January 2022
HEE NE to arrange dates with LEPs for 2022 ADQMs	From November 2021
HEE NENC Quality and Patient Safety Conference	9th March 2022
Anticipated dates for 2022 GMC NTS Trainee & Trainer Surveys	April - May 2022
2022 Annual Dean's Quality Meetings (ADQMs) with Trusts	May - July 2022
Quality Team to send 2021/22 End of Year Trust Reports and Grids to LEPs	August 2022

On behalf of HEE North East & North Cumbria August 2021

Professor Namita Kumar
HEE NE Postgraduate Dean

Mr Pete Blakeman
Deputy Postgraduate Dean & Quality Director

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Appendix 1

Version Control: 2020/21 Year End	HEE North East & North Cumbria Current View of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust						
GMC TRAINEE NTS 2019	GMC TRAINER NTS 2019	CQC Rating	NHSI Segment Rating	CNE QSG Monitoring	Initial Education Contract (LDA) HEE NE Funding 2020/21:		
9/206 HEE 9/233 UK	9/206 HEE 9/233 UK	OUTSTANDING G, O, O, O, O July 2018	1	ROUTINE	£ 7,447,710		
	Current HEE Intensive Support Framework Escalation Levels						
	HEE Overall ISF escalation	Domain 1 Learning Environment & Culture	Domain 2 Educational Governance & Leadership	Domain 3 Supporting & Empowering Learners	Domain 4 Supporting & Empowering Educators	Domain 5 Delivering Curricula & Assessments	Domain 6 Developing a Sustainable Workforce	Comments/Concerns
HEE view of LEP at organisational level	0	0	1	0*	0*	0	0	Overall: 1: 2: Governance of system & post changes 3: Year on year ranking in trainee NTS 4: Year on year ranking in trainer NTS 5: 6:
System view of Service Groups	CQC ratings of Service Groups	HEE ISF Escalation Levels of Training Posts & Programmes by Domain						Negative / Positive
Adults of Working Age	G	0	0	0	0*	0	0	
Child & Adolescent	O	0	0	0	0*	0	0	
Community	O	0	0	0	0*	0	0	
Older People	G	0	0	0	0*	0	0	
Forensic	G	0	0	0	0*	0	0	
Rehabilitation	O	0	0	0	0*	0	0	
Learning Disability	O	0	0	0	0*	0	0	

Summary of current and recent issues being monitored by HEE NE&C	Supportive Learning Environment		GMC Assurance Activity
Issues being actively monitored • Governance of system & post changes with recent trust reconfiguration **Recently resolved issues** • Core Psychiatry: St Georges Morpeth • Old Age Psychiatry: St Georges Morpeth	**POSITIVE** Foundation Psychiatry Old Age Psychiatry – incl Trainers Rehabilitation Learning Disability - Trainers	**NEGATIVE**	**Themes arising from GMC Regional review** • Identification of leaners • Process for raising concerns For information: New GMC quality assurance cycle starting with HEE NE&C in 2021. This may involve active GMC participation in routine HEENE&C/ LEP quality management processes this year.

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Report to the Board of Directors
6th October 2021

Title of report	**Medical Appraisal/Revalidation Annual Board Report 2020-21**
Report author(s)	**Dr Rajesh Nadkarni, Executive Medical Director** **Professor Eilish Gilvarry, Deputy Medical Director**
Executive Lead (if different from above)	**Dr Rajesh Nadkarni, Executive Medical Director**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing		Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability	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	29/09/21
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

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

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

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

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Medical Appraisal/Revalidation Annual Board Report 2020-21

Board of Directors
6th October 2021

1. Executive Summary

This Report is the Annual submission of Medical Appraisal and Revalidation. The Board are asked to sign, after agreement, the Statement of Compliance. This Annual Report is to be reviewed by the Quality and Performance subcommittee on /9/2021 and will then be submitted to the Board for agreement and sign off before being forwarded to NHS England.

2. In brief:

- Compliance for appraisals- were 100% for 2020/21 (apart from exempt and agreed deferrals)
- 41 trained appraisers-all updated with training
- 31 doctors were recommended for Revalidation - one deferred, one on hold and 2 have been Revalidated early
- No issues of non-engagement
- CPD lunchtime sessions continue via Microsoft Teams and well attended
- Working on a collaborative teaching programme, offering education and networking to GP and GP trainees across the North East and Cumbria.

3. Risks and mitigations associated with the report

- Revalidations deferred due to COVID
- Team updating all doctors on changes and linking with regional teams
- CPD changed to online for present with development

4. Recommendation/summary

The Board are asked to accept this report and sign the statement of compliance at Section 7.

Dr Rajesh Nadkarni
Executive Medical Director

Professor Eilish Gilvarry
Deputy Medical Director

20-9-2021

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Designated Body Annual Board Report – Medical Appraisal/Revalidation 2020-21

Section 1 – General:

The Board of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Rajesh Nadkarni, Executive Medical Director is the Responsible Officer for the Trust and St Oswald's Hospice.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

The Revalidation Team consists of: Professor Eilish Gilvarry, Deputy Medical Director, Dr Hermarette Van den Bergh, Associate Medical Director – Revalidation, Dr Sunil Nodiyal, Associate Medical Director – Appraisal, Revalidation Admin Team and 41 trained and active appraisers an increase of 3 from last year.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The Revalidation Administration Team regularly checks with GMC Connect to ensure appropriate doctors are connected to the Trust and any leavers have been disconnected.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The following policies were reviewed, updated and ratified, as per the previous Work Plan: Private Practise, Job Planning, Medical Appraisal and Request for Change of Consultant. The organisation updated the Clinical Supervision Policy, and in consultation with medical staff, through MSC, LNC and the BMA, a PGN applying to medical staff was written and ratified. As a result of CNTW commitment to improved documentation of peer review and clinical supervision processes,

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we endeavour to evidence this through the Appraisal process. In order to provide the necessary quality assurance, the audit process of appraisal outcomes has been duly amended to reflect this.

Handling Concerns about Doctors policy, also due for review this year, has been fully reviewed and updated in collaboration with Capsticks. The updated version is currently under consultation with LNC (August 2021).

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

In accordance with the agreed Audit Programme for the financial year 2020/21, an audit of the appraisal output was done, using the NHS England approved audit tool ASPAT as previously. Following consultation with medical staff and the Appraiser Development group, the ASPAT audit tool was amended, to include a unique CNTW extension. This is a separate, additional section, containing five domains which cover the changes in the MAG2020 around wellbeing, as well as a section on additional documentation for peer review and multi-disciplinary clinical discussions. This was to provide quality assurance on a number of additional domains, of both local and national relevance. These include changes to the appraisal process in response to the pandemic (MAG 2020 model), as well as the commitment to improved documentation of supervision and peer review.

The results are very encouraging, maintaining a trend of improvement across all domains year on year. This provides evidence of the value of the Appraiser Development Group and the positive impact of discussing previous audit outcomes in this forum. The results on the CNTW extension shows a further helpful trend towards discussing the impact of the pandemic and clinical welfare, which is in keeping with the changes proposed in the MAG 2020.

We are encouraged by the commitment of our clinicians and their continued engagement in the appraisal process, despite pressures relating to the COVID-19 pandemic.

As with previous audits, the results and learning points will be discussed in the Appraiser Development Group, to facilitate quality improvement and greater compliance.

A further audit will be incorporated in our Workplan for 2021/22.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

The Locum Support Document/Checklist was updated and re-circulated to all Medical Managers. The document is also sent to the supervisor/ line manager

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each time a locum is appointed. The updated guidance from NHS England 'Supporting Locums & Doctors in Short-term Placements' has been reviewed (2019/20). There have been additional documents implemented for use when booking locum doctors ie: Agreed Agency Timetable, which provides details of the sessional work the doctor will be required to undertake, and is signed off by the supervising consultant, finance for costings and the actual locum doctor, so they know exactly what is expected when they report for work. This avoids any issues when it comes to authorising timesheets and working additional hours. Updates to financial reporting have been introduced on agency spend. The process for booking agency doctors was recently revisited in medical managers meeting in July 2021, and new structures are now in place for agency approval.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

There is a Priming Appraisal process in place to ensure all newly appointed doctors meet with the Appraisal/Revalidation Admin Team and hold an initial meeting with nominated appraiser to agree Personal Development Plan (PDP) within first 3 months of appointment.

Due to COVID-19 NHS England agreed deferrals to appraisals for doctors during the period 1st April to 30th September 2020 for a 12 month period. However quite a majority of doctors within the Trust proceeded to undertake their appraisal despite this offer.

<u>Apr to Sept 20</u>
86 - Doctors were due to complete appraisals during this period
55 - Completed during the deferral period
5 - Exemptions due to Sickness, Maternity Leave
26 - Deferred but have subsequently/will have undertaken their appraisal within the 12 month period
<u>Oct 20 to Mar 21</u>
146 - Doctors were due to complete appraisals during this period

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140 - Completed as required
6 - Exemptions due to sickness, Maternity Leave

Out of a total of 232 doctors in 2020/21 there were 195 Appraisals completed, 26 agreed deferrals (all of whom have subsequently completed or planned their appraisal) & 11 exemptions. No deferrals were made due to non-engagement.

The numbers outlined above are testament to our clinicians' commitment and engagement with the appraisal process, continuing with their appraisals despite the pandemic or the offer of deferral.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Not applicable

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Medical Appraisal Policy is in place and recently reviewed. The next review date is September 2023.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Within the year 2020/21, there were 41 trained appraisers following training and induction of 7 new appraisers. The new appraisers were appointed following resignations or retirement of a few appraisers and expansion of the Fellowship scheme in the trust. This also include two new appraisers specifically for the international fellow doctors. These international fellow doctors usually have no experience of appraisals and need more time and attention to be familiarised with the process. The total numbers includes 2 appraisers from St Oswald's Hospice as well.

Appraiser Refresher training is being booked for November 2021 to capture the appraisers who require refresher training in December 2021.

Action for next year: Continue to monitor number and training of appraisers. We also intend to review the appraiser training, to include a renewed focus on wellbeing as well as the recommendations included in the Fair to Refer report.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

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events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

All appraisers must attend a minimum of one Appraiser Development Group meeting which are held throughout the year to provide updates and discussion on relevant themes, though greater participation is recommended and encouraged. These themes include feedback from Regional RO/Appraisal Leads Meetings, SARD training sessions and individual appraisal feedback.

All appraisers complete formal training prior to taking up the role and attend formal refresher training at a minimum every 5 years. A central database of this training is updated accordingly by the Revalidation Admin Team. There are a number of appraisers due to renew their training before December 2021.

In the 2020/21 appraisal year, all appraisers but one attended at least one Appraiser Development Group. This Appraiser, who was not able to attend any due to working Part Time, was sent a recording of one session to watch and comment on with the appraiser lead to ensure compliance.

Further, the team have linked in with the regional network to ensure we are updated with all changes and developments and bring these changes/updates to the CNTW appraiser group, and larger medical staffing cohort, via attendance and updates at the Medical Staff Committee meetings.

Action for next year: Continue with Appraiser Development Meetings, review appraiser training records and provide relevant updates when necessary, including refresher training for identified appraisers. The ASPAT Audit undertaken in 2020/21 will be discussed with the appraisal team (post COVID crises) to improve the quality of appraisal output and alignment with NHS England standards for appraisal. The meetings will address and focus on health and wellbeing and ongoing support through appraisal for all doctors, especially those particularly impacted by the pandemic and associated restrictions. The team also reviews the electronic appraisal platform regularly.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

External Audit (Audit One) reviewed the system as part of their annual plan 2018/19 with substantial assurance being granted. We have completed all minor changes requested. The ASPAT audit tool has been reviewed and now includes a unique CNTW amendment, which provides assurance on appraisers reviewing wellbeing of the appraisees, as well as the impact of the pandemic, as per recommendations made by the GMC in 2020.

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[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Annually the appraisal summaries and outcomes are reviewed using the ASPAT Tool, to measure compliance with NHS England standards. In the review of 2020/21, in all cases, the minimum standards for appraisal evidence were met by appraisees. However, certain domains within the appraisal summary were identified for development, e.g. improved documentation of clinical supervision and peer review. This will be reported to and reflected upon by the Appraiser Development Group. All appraisers who had completed appraisal output summaries, not meeting the required minimum standard, will be individually contacted and areas for development agreed.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	232
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	195
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021 due to agreed deferral	26
Total number of agreed exceptions	11

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Due to the pandemic, the GMC offered deferral of all revalidations due between 18 March 2020 and 17 March 2021. At the time of the AOA report for 2019/20 all revalidations were up to date up to the end of April 2020, and those were not affected by the offered deferral.

However, doctors were advised that they were still free to submit an application for revalidation if all evidence was in place, and they could revalidate on time. Their next revalidation date would still be amended to 12 months, and they would effectively start their new cycle from the deferred date.

For the rest of the period covered by this report, there were 35 revalidations due. We continued with the review of evidence and recommending revalidation for our doctors, to acknowledge their work and commitment. 31 revalidations

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were completed early, 2 revalidations were done at the new agreed time, 1 have been deferred and 1 is on hold. As for the appraisals, this is a testament to the hard work and commitment shown by our clinicians, most of whom had all the evidence required.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All recommendations submitted were done so in a timely manner. Any deferral is discussed with the individual doctor concerned. A letter is issued to the doctor outlining the reasons for deferral. However, the revalidation requirements are discussed as part of the penultimate appraisal and plans to attain the relevant standards discussed. All appraisers are advised, at the penultimate appraisal, to inform the Revalidation Admin Team of any concerns that have been identified if a doctor may not be on course for Revalidation.

We were up to date with all revalidations up to and including 30/04/20. Given the above offer from the GMC, the revalidation team supported our clinicians by proceeding with the Revalidation evidence review process, despite GMC deferral, and recommended revalidation for all clinicians with sufficient evidence. Our aim was to recognise the work already done by clinicians and to maintain the support, recognition and development for clinicians. The numbers that were effectively able to revalidate early is evidence of the success of this approach.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Handling Concerns about Doctors Policy was reviewed and is currently at LNC for approval. Regular support meetings are held with all Medical Managers throughout the year to discuss themes and ensure adequate support/action plans are in place, for those doctors where there are performance, competency or health issues. RO & Deputy RO meet regularly with the GMC Employment Local Advisor (ELA).

Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The Trust adapted the MAG 2020 model but continued to use the SARD template. SARD fully reflects all changes made to the MAG2020, to help doctors understand what they need to do to prepare for and participate in the appraisal, and to help appraisers ensure that any appraisal is carried out

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consistently and to a high standard. We regularly updated all the doctors within the designated body of the changes to the appraisal model during COVID, and of the need (or not) for appraisal. This was updated through Medical Staff Committee, individually with some doctors, through regular 'Microsoft Teams' meetings with the Medical Director, provided links to the Academy of Medical Royal Colleges advice, newsletters and with discussions with the Appraiser Development Group. Such an appraisal, done during the pandemic, was to offer a confidential professional discussion about their experience of the pandemic and provide a chance for them to reflect on their health and well-being, these seen as essential factors for high standards of professional practice. This was especially relevant for some doctors who have been personally impacted by COVID-19, and doctors who are at additional risk from COVID-19. Advice was given on refocusing/rebalancing the appraisal with greater flexibility eg preparation time, quality rather than quantity, emphasis on well-being and development, avoiding a tick box approach and recognition of the value of reflections - these often verbal rather than written reflections.

There are regular Supporting Doctors/Handling Concerns management meetings (attended by Executive Medical Director, Deputy Medical Director, Group Medical Directors, Head of Medical Recruitment and Education & or Medical Staffing Manager). Some training is given during these meetings, eg Practitioner Performance Advice (PPA) and GMC proceedings. Any informal concerns are included in action plans and the doctor is asked to reflect and discuss this as part of their annual appraisal. In 2019/20 the medical revalidation team developed, in collaboration with Group Medical Directors, a sign off template, for medical managers to include in appraisal. This process ensures that performance management is linked with appraisal, and quality assured, without unduly disrupting the supportive element of appraisal process. Due to the pandemic and the focus shift in appraisals, this has not been fully implemented, but forms part of the workplan for 2021/22.

In line with the GMC report Fair to Refer, we reviewed the process above and include mechanisms to capture data on protected characteristics of clinicians under performance management.

2. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The Handling Concerns about Doctors Policy has been reviewed and updated with Capsticks (HR Advisory Service) who are, also involved in all levels of concerns about doctors. Training is provided to all Medical and Operational Managers on the Handling Concerns about Doctors process. We approach performance issues sensitively, and ensure the doctor is supported at all stages of the process (both informal and formal). Themes and learning points on process are discussed and reflected upon with medical managers.

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Action for next year: Continue to provide refresher training on the Policy/Process to new medical managers, to include making managers and doctors aware of 'Fair to Refer' report. Roger Kline, the author of the report, has been commissioned by CNTW to advise and be a critical friend in relation to diversity and inclusion issues. He will be asked to assist with any of these matters as required in 2020/21.

3. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

The Annual Revalidation Report is provided to the Trust Board which provides assurance and highlights any risks/concerns identified throughout the year. Medical Managers' Meetings are held bi-monthly to review any issues identified, with the Head of Medical Recruitment and Education, Workforce, and Capsticks in support, as required. This meeting reviews numbers within HCAD, sharing learning, areas of improvements and reflective practice. Non-Executive Directors are linked into any suspensions of medical staff as per the Policy. Regular meetings are held with GMC Employment Liaison Officers.

4. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

All new doctors joining CNTW are subject to NHS Pre-Employment Checks of which one is to ensure satisfactory completion of Appraisal in the last 12 months. Medical Practice Information Transfer (MPIT) forms are also sent to last employing organisation which allows information to be shared between Responsible Officers. These responses to other organisations are conducted in a timely manner.

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[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

5. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

All policies are subject to Impact Assessment as part of the review process.

The 'Fair to Refer' Report written by Roger Kline and team on behalf of GMC in June 2019 was reviewed as part of the Local Work Plan to ensure Trust processes are in line with the recommendations. The Medical Revalidation Team completed a review of our processes, using the Effective Clinical Governance for the Medical Profession self-assessment tool (GMC, 2018), and the following was implemented and/or agreed:

-Appraisee has a choice of appraiser: this is CNTW current practice within the Appraisal process.

-Fair to refer document discussed and checked all policies are in line with this document.

-HCAD policy reviewed to ensure due consideration given to appropriate diversity and equality issues

-Agreed to include in our workplan a review of our data capturing processes to ensure we appropriately capture data on protected characteristics

-Train doctors as cultural ambassadors' to support other doctors, especially those with performance or health issues.

– Mentoring and coaching is actively encouraged for all the new starters and anyone in need of it. The new starters are informed about the programme during the corporate induction and also during the appraisal training. The revalidation team manages the request for mentoring. When a request is received, the Mentee is sent a questionnaire to complete and based on the preference set in the answer, the revalidation team matches them to the mentors in the trust, with the option of choice. All the mentors are expected to have regular training every 5 years to stay up to date and a list of qualified and up to date mentors and coaches is maintained by the revalidation admin team.

Workplan 201/22: We are in the process of reviewing and improving the mentoring programme and plan to start a development group for mentors meeting regularly. We are also considering to offer mentoring to SAS grade doctors and other doctors, including the International Fellowship Programme and non-training posts.

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Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

As part of the Medical Recruitment process for all medical posts within the Trust (substantive, fixed term and agency locums) the NHS Pre-Employment Checks are undertaken. This includes the doctor providing evidence on: Verification of ID, References, OH, DBS, Qualifications, GMC Registration, Right to Work, and where relevant Approved Clinician and Section 12 Status. Providing details of current Responsible Officer and a copy of Appraisal undertaken in the last 12 months.

Section 6 – Summary of comments, and overall conclusion

Actions for 2020/21 and completed :

- **CPD Events** – we continued to run a full weekly CPD programme on a virtual platform. This has expanded to include a pilot mental health CPD scheme for GPs as well as a number of half days for consultants, covering a range of topics.
- **ASPAT Audit –** completed for 20/21, with CNTW amendment. Results to be presented to Appraiser Development Group and learning points discussed
- **Supporting Locums & Doctors in Short-Term Placements** - Following Review of NHS England document, amend CNTW support document with Head of Medical Recruitment in 2020/21
- **Update -** Revalidation Team Members & Appraisers with all National Developments- continued attendance with regional network
- Discussion on **personal well-being** throughout all appraisals, assurance on this provided through update of ASPAT audit
- Updating through multiple areas the **changes in the MAG 2020** and their implications for doctors
- **Change to CPD programme** to allow all doctors to gain CPD that was useful for development but less time
- Embracing video conferencing, teams meetings, updates and undertaking appraisal through Microsoft teams

Overall conclusion:

The Appraisal/Revalidation Team Local Work Plan for 2020/2021 was successfully completed, with the exception of ongoing work on the mentoring process. We are proud to report that despite offered deferrals and the challenges of the pandemic, our appraisal completion rate (including the agreed deferrals) was 100%, with only 11 exemptions, none for non-engagement. The few who opted to avail themselves of the offer of deferral, have also now completed appraisals or have planned their appraisals for the last two

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years. Similarly, despite challenges, pressures and the option of deferral, the revalidation process has continued successfully with all revalidations completed, apart from 1 deferral, unrelated to non-engagement. Much thanks go to the Appraisers and the entire medical workforce, for their continued enthusiasm and engagement with the Appraisal/Revalidation process. We continue to have great pride in our work and achievements, and the flexibility we have been able to offer. Regular communication with the medical workforce remain a priority, as is the continuation and development of our CPD programme, through which we provide opportunities for development and support for revalidation.

The challenges for the team in the year ahead include:

- Review the financial aspects for our CPD programme, despite the restriction on large meetings
- Consideration given to the benefit of further expanding our CPD programme to include other professions and organisations
- Ensure transparency and fairness in all appraisals and any work performance issue
- Maintain links with NHS England in view of possible further changes and review of appraisal system
- Embedding the changes made in MAG2020 in the appraisal process and ensuring consistent quality of the process across the board
- Review of the administration roles in the revalidation and CPD team in line with the new expansion of the CPD programme and the Medical Workforce strategy.

- **Summary**

In 2020/21 there were 232 doctors with a prescribed connection to the Trust.

195 doctors had a completed appraisal in support of their revalidation, with 26 doctors taking up the offer from GMC to defer for 12 months, (although all of these have now either planned or completed their appraisal) and 11 doctors had adequate reasons for incomplete appraisals (such as long-term sickness or maternity leave). There were more appraisals completed – this related to some doctors leaving during the year and new doctors arriving. At the end of March 2021 the appraisal compliance for the Trust was at 100%.

As part of the revalidation process 33 doctors had positive recommendations made to the GMC within the year.

Policy and guidance

The relevant policies are: -

- Medical Appraisal Policy and Medical Appraisal Practice Guidance NTW(C)33,V03
- Medical Job Plan Policy CNTW(C)56,V02
- Private Practice Policy CNTW(O)46,V02
- Handling Concerns about Doctors Policy CNTW(HR)02, V02

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- Service Users requesting a Change of Medical Consultant or Second Opinion CNTW(C)42, V05
- Clinical Supervision Policy CNTW(C) 31, V06.1

- **Appraisers**

During the period 2020/21 the Trust had 41 fully trained appraisers who meet regularly to discuss current appraisal issues, calibrate their judgements, problem-solve and to share good practice. Attendance and engagement with these meetings continue to increase, with positive feedback received from Appraisers regarding topics for discussion/debate.

We continue to update the SARD system as needed, and communicate these changes to the appraiser group.

Section 7 – Statement of Compliance:

The Board of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _ _ _ _ _ _

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NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
6th October 2021

Title of report	**Annual Emergency Preparedness, Resilience and Response 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 Emergency Preparedness, Resilience and Response Report – 2020 / 2021

Board of Directors Meeting
6th October 2021

1. Executive Summary

This report provides an annual update in relation to activity of Emergency Preparedness, Resilience and Response (EPRR) from April 2020 to March 2021. This report also includes the NHS England Core Standards Assessment for 2020 / 21, which then forms part of forward plan for the Trust's EPRR systems support the Trust in ensuring it is prepared to respond to all events planned and unplanned, in an ever-changing environment, and this has been facilitated over the last year. This is important with the national focus on terror related events and cyber security incidents on the increase. The Trust is well placed and actively involved in local plans to improve and respond to the areas should the need arise. The Trust has supported a number of national conversations in relation to further development of plans in relation to Hospital Lockdown and Evacuation.

The EPRR Team has supported the continued efforts in relation to the pandemic and has been one of the strategic links between regional support and the Trust's Incident Management Group. In line with previous agreed governance arrangements, any operational issues of note have been fed through the COVID 19 – IMG throughout 20 / 21, due to the standing down of the EPRR meeting, and the fact that most members are members of IMG as well.

2. Background

The Health and Social Care Act 2012 requires all NHS organisations to plan for and respond to a wide range of incidents that could impact on health or patient care. This includes significant incidents or emergencies such as prolonged periods of pressure on services, extreme weather conditions, infectious disease outbreaks or a major transport accident. The programme is referred to as (EPRR).

Core Standards and supporting guidance from NHS England set out the parameters for Trusts to adhere to in relation to Emergency Preparedness. The Trust is also required by the Health and Social Care Act (2008) Regulated Activities Regulations (2010) to have plans in place for dealing with emergencies.

The Civil Contingencies Act 2004 (CCA) provides the framework for emergency preparedness in the UK. Although Mental Health Trusts do not currently have statutory obligations under the CCA, the Department of Health and NHS England require all NHS providers to adhere to the principles of the Act.

3. Governance Arrangements

3.1 Responsible Officers

The Trust has in place an Accountable Emergency Officer, this role is undertaken by the Chief Nurse. This role was supported by the Deputy Chief Operating Officer in his capacity as Director of EPRR, this function transferred following the Executive portfolio changes in March 21, and now sits with the Director of Safety and Innovations.

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The operational functions of EPRR are now carried out by the Head of Safety, Security and Resilience supported by the Safety, Security and Resilience Manager. The alignment of EPRR into the Safety and Security function, benefits the alignment of the EPRR agenda, but unusually there are only 2 of these roles in organisations across the North East and Yorkshire.

The regional NHS Improvement team has a weekly catch up with all Trust EPRR leads, to discuss planning and any emerging issues, these have continued throughout the pandemic, and will maintain as we “live with covid”, and as part of return to normal.

EPRR – Policy and Guidance

There were minor changes to the Trust’s Emergency Preparedness, Resilience and Response Policy – NTW (O)08 in to reflect the change of Director lead. There were also updates to both the Cold Weather Plan and the Heatwave Plan to reflect changes from national documents.

A new staffing escalation PGN is in development and being tested across the organisation, due to the increased staffing pressure seen over the last year, due to absence both covid and non-covid, couple with level loaded leave and current vacancies. This also resulted in a re-deployment meeting taking place each Friday, in relation to the movement of staff from Corporate teams and Community clinical teams, to support in-patient teams that are under pressure.

In previous experience staffing escalation has only minimally impacted in the organisation due to adverse weather and temporary shortage of staff, so this new guidance will support decision making at all levels of the organisation.

4. Governance Arrangements

In business as usual processes the Trust is required to support and attend a number of regional meetings to provide input and support regional plans. During the pandemic a number of meetings have merged, been stood down or have been absorbed into incident response into the pandemic. The trust has inputted into all these meetings, with the majority co-ordinated through Gold Command and escalated outputs back through COVID – IMG and into the Executive Team , Care Groups and to the board as required. No concerns have been identified from this approach which is mirrored across all healthcare providers.

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5. Incidents Occurring across the Trust

The Trust has continued to manage the incident system across the Trust with EPRR leads notified about specific incidents. The following table gives a breakdown of the incidents that occurred, with each one reviewed by clinical / operational teams, support by corporate teams such as digital services or NTW Solutions. All incidents are reviewed by the EPRR leads, to look for trends or where there is recurring, repeat activity, none of the reported incidents hit the serious incident threshold. Any incidents relating to COVID 19, are not included as these have been reported on separately through COVID updates to the Board.

Cause 1	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
IN01 Loss Of Telecommunications	6	1	4	5	7	3	3	0	5	2	0	8	44
IN02 Loss Of Electricity	0	1	1	1	0	1	3	1	0	0	0	0	8
IN03 Loss Of Water	0	0	0	0	1	3	1	4	1	0	0	0	10
IN04 Server Failure	1	4	0	0	2	0	2	0	1	0	1	1	12
IN05 IT Network Failure	0	2	11	5	4	4	1	3	5	1	3	5	44
IN06 Network/computer Virus Discovered	0	1	0	0	0	1	0	0	1	0	1	0	4
IN07 Lift Failure	0	0	0	0	1	0	0	0	0	1	0	0	2
IN08 Gas Leak	0	0	0	0	0	0	1	0	0	0	0	0	1
IN09 Failure Of Fixture & Fittings	1	3	1	5	4	5	5	1	1	4	1	0	31
IN10 Clinical Record Access Issues	0	3	3	0	3	3	1	1	0	0	2	0	15
IN11 Flooding	1	7	0	2	0	2	1	2	0	1	1	0	17
IN12 Loss Of Heating	0	0	0	0	0	0	1	2	1	4	4	0	12
IN13 Environmental Issue	0	1	1	2	2	2	1	0	3	3	1	3	19
IN14 Information System Failure	0	0	3	0	1	0	1	2	3	2	2	2	16
IN15 Environment Too Hot	0	0	5	0	3	2	2	0	1	0	1	0	14
IN17 Weather Related Incident	0	0	1	0	0	0	0	0	2	2	2	0	7
Total	9	23	30	20	28	25	23	16	24	20	19	19	256

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6. NHS England / Improvement Core Standards 2020 / 2021

NHS England undertakes an annual assurance process against a set of core standards for Emergency Preparedness, Resilience and Response (EPRR).

The assurance process for 2020/21 was received in July 2021 from NHS England, with the self-assessment. It is a requirement of the assurance process that the statement of compliance is reported to the Board of Directors / Governing Body Meeting. These standards have been assessed and presented through to COVID -IMG in relation to being received by a corporate group in absence of the EPRR meeting which is due to stand back up in October 2021.

There are 58 core standards questions of which 37 apply to Mental Health care providers.

This year there is also a thematic deep dive in relation to Oxygen management, which is applicable to the Trust, and relates to the previous pressure experienced across the system in response to the pandemic.

Link to standards here

As in previous years the assessment of the standards has been carried out by the Head of Safety, Security and Resilience and the outcome shared with the appropriate Governance group and in this case in absence of the Trusts EPRR meeting, it has been shared through the COVID 19 – IMG.

This report should be received for information and assurance that the EPRR arrangements have remained in place through the last year.

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Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

01/10/2021	06/10/2021	06/10/2021
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Tony Gray
Head of Safety, Security and Resilience

Gary O'Hare
Chief Nurse (Accountable Executive Officer)

29 September 2021

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