Board of Directors meeting held in Public

Wed 02 February 2022, 13:30 - 15:30

Via MS Teams

Agenda

1. Welcome and apologies for absence

Ken Jarrold, Chairman

2. Declarations of interest

Ken Jarrold, Chairman

3. Service user / carer / staff story

4. Minutes of the meeting held 1 December 2021

Ken Jarrold, Chairman

4. Board Public Minutes 1 December 2021 FINAL.pdf (8 pages)

5. Action log and matters arising from previous meeting

Ken Jarrold, Chairman

5 BoD Action Log PUBLIC as at 2.2.21 DH.pdf (1 pages)

6. Chairman's update

Ken Jarrold, Chairman

7. Chief Executive's report

James Duncan, Chief Executive

7. CEO Report February 2022.pdf (6 pages)

Quality, clinical and patient issues

8. COVID-19 response update

Gary O'Hare, Chief Nurse

8. Covid 19 Board Update - Feb 2022.pdf (7 pages)

9. Commissioning and Quality Assurance Report (Month 9)

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

9. Monthly Commissioning Quality Assurance Report - Month 9.pdf (14 pages)

10. NHS community mental health survey benchmark report 2021

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

10. Community Mental Health Survey 2021 (002).pdf (8 pages)

11. Service user and carer experience report (quarter 3)

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

11. Service User and Carer Experience report Quarter 3 2021-22.pdf (9 pages)

12. Safer staffing levels report (quarter 3)

Gary O'Hare, Chief Nurse

12. Safer Staffing Monthly Report inc 6 Month Skill Mix Jan 2022 - Trust Board.pdf (28 pages)

13. Involvement Service

Alane Bould, Head of Involvement

Workforce issues - no issues to report

Strategy and partnerships update

14. Integrated Care System / Integrated Care Board update

verbal update *James Duncan, Chief Executive*

15. Sunderland Place Based Arrangements

James Duncan, Chief Executive

15. Sunderland Place Based Governance arragements 2022.pdf (10 pages)

Regulatory items

16. CQC Action Plan update

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

16. CQC Must Do Action Plans Q3 Update Final v2.pdf (31 pages)

17. Board Assurance Framework / Corporate Risk Register report (quarter 3)

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

17a. Trustwide Risk Management Report - Dec 21.pdf (10 pages)
17b. Appendix 1 - Trust-wide Risk Management Appetite Report - Dec 21.pdf (1 pages)
17c. Appendix 2 BAF-CRR Risk Register Q3.pdf (26 pages)
17d. Appendix 3 Trust-Wide Risk Management Report - Dec 21.pdf (18 pages)
17e. Appendix 4 - Trust-wide Risk Managment Internal Audit - Dec 21.pdf (3 pages)
17f. Appendix 5 - Trust-wide Risk Managerment Clinical Audit - Dec 21.pdf (5 pages)

18. NHSE/I Single Oversight Framework compliance report (quarter 3)

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

18. NHS Improvement Single Oversight Framework - Quarter 3 2021-22.pdf (5 pages)

19. Infection Prevention Control (IPC) Board Assurance Framework

Gary O'Hare, Chief Nurse

19a. IPC BAF - Feb 2022.pdf (5 pages)
19b. BAF C1501_Infection prevention and control board assurance framework Q3 Jan 2022 (002)am.pdf (18 pages)

20. People Committee Terms of Reference

Darren Best, Committee Chair

20. People Committee Terms of Reference Final - January 2022 (003).pdf (7 pages)

21. Trust Self-Assessment Report and Quality Improvement Plan

Rajesh Nadkarni, Executive Medical Director

21a. Trust Self-Assessment & Quality Imporvement Plan.pdf (2 pages)
21c. 2019-20 CNTW GRID (1).pdf (1 pages)
21d. QIP CNTW updated Jan 22.pdf (11 pages)
21b. Self-Assessment Report (SAR) signed 28.01.22..docx.pdf (61 pages)

Board Sub-Committee minutes and Governor issues for information

22. Quality and Performance Committee

Alexis Cleveland, Chair

23. Audit Committee

David Arthur, Chair

24. Resource Business and Assurance Committee

Paula Breen, Chair

25. Mental Health Legislation Committee

Michael Robinson, Chair

26. Provider Collaborative Committee

Michael Robinson, Chair

27. Charitable Funds Committee

Louise Nelson, Chair

28. CEDAR Programme Board

James Duncan, Chief Executive

29. Council of Governor issues

Ken Jarrold, Chairman

30. Any Other Business

Ken Jarrold, Chairman

31. Questions from the Public

Ken Jarrold, Chairman

Date and time of next meeting - Wednesday 2 March 2022, via MS Teams

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

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

John Lawlor, Chief Executive
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:
Kirsty Allan, Acting Corporate Affairs Manager (Minute Taker)
Tom Bentley, Staff Governor, Public Gateshead
Evelyn Bitcon, Public Governor for North Cumbria
Russell Bowman, Service User Governor for Neuro-disabilities
Revell Cornell, Staff Governor – Non-Clinical
Fiona Grant, Service User, Adult Services
Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary
Julie Lawlor, Associate Director, North Cumbria
Raza Rahman, Staff Governor, Clinical
Paul Richardson, Appointed Governor for North Tyneside Council
Wendy Ritchie, Service User *(for item 3)*
Jayne Simpson, Corporate Affairs Officer
Bob Waddell, Staff Governor, Non-Clinical
Jane Welch, Policy Advisor
Victoria Wilson, Patient and Carer Involvement Facilitator *(for item 3)*

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

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

3. Service User/Carer Story

Ken Jarrold extended a warm welcome and thanks to Wendy Ritchie who attended the Board to share her story.

4. Minutes of the meeting held 3 November 2021

The minutes of the meeting held on 3 November were considered.

Approved:

- **The minutes of the meeting held 3 November 2021 were approved as an accurate record.**

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

04.08.21 (10) Lisa Quinn confirmed additional narrative will be added to the Commissioning and Quality Assurance reports going forward. Lisa confirmed that there is currently no national definition for the approach to monitoring waiting times, but a national definition was expected to be clarified from 1st April 2022 for most services in terms of access standards. It was agreed to remove the action as complete.

01.09.2021 (13) Lynne Shaw advised that narrative relating to exit interviews would be included in the quarterly workforce report outlining themes. Following the establishment of the People Committee from January 2022, Lynne suggested working with the Chair of the People Committee to review the content and focus of the quarterly workforce report to Board.

Following the development of the People Committee, Alexis Cleveland referred to discussions resulting in work to review reporting to Quality and Performance Committee, Resource and Business Assurance Committee and the People Committee to ensure an appropriate level of triangulation is maintained, balanced with a reduction in duplication. As part of this review, Alexis suggested that clarification be made as to which reports are statutory and non-statutory.

Action:

- **Clarification regarding which workforce-related reports are statutory and non-statutory – to be reported into the People Committee**

6. Chairman's Remarks

Ken Jarrold referred to the recent Board Away Day, at which the challenges faced by the Trust and the NHS was discussed. It was clear that the Trust would need to engage very well with partners, service users, carers, primary care, social care, the third sector and staff, to develop a co-owned approach to the sustainability and delivery of services in the light of the impact of the pandemic.

Ken referred to staffing issues as a further priority and assured the Board that everything is being done to address the issue.

Ken also referred to the way the Trust deals with issues with a strong level of openness, honesty, and transparency. Ken stated that it was more important than ever to be open with each other at every level about the challenges the Trust is facing.

Ken referred to government's decision on the requirement of mandatory vaccinations for health and care staff which will create very difficult situations for some people. It was recognised that the next few months will be very challenging for everybody including staff directly affected.

Ken Jarrold stated that the meeting represented the final CNTW Board meeting for both John Lawlor and Peter Studd. Peter, Chair of NTW Solutions and Chair of the Resources and Business Assurance Committee. Ken said that Peter will be greatly missed by all saying it had been a privilege to work with him and acknowledging his exceptional contributions to the Board. Peter Studd thanked everyone saying it has been a pleasure working for the Trust during his tenure of six years and he felt very proud working with an outstanding team.

Ken Jarrold shared with the Board his response to John Lawlor's decision to retire from the Trust as Chief Executive.

"When I joined CNTW, I asked everyone what they wanted me to do as Chair, the answer was simple and powerful. Look after John! It has been my privilege to support you as best I could. The advice I was given was based on the respect and love those colleagues feel for you. I know that you would be the first to agree, that many of the things that make CNTW so special have been developed by thousands of colleagues over many years, however you are the one who brought all those wonderful things together, to make CNTW an outstanding Trust. You have inspired service users, carers, colleagues, and partners by your openness, about your own issues, your humanity and dignity at times of trouble. You are one of the best Chief Executives in the NHS and have made a much-valued wider contribution in the region and at national level. You will be remembered and missed as a leader, manager, colleague, and friend. Working with you, has been one of the greatest privileges of my working life. I look forward to the immense contribution that you will make in the next stage of your life and to keeping in touch, so that I can continue to learn from you".

Other Board members joined Ken in acknowledging John's impact on the organisation, his colleagues, service users and carers.

John said the role of Chief Executive at CNTW had been the best job he has ever had and thanked service users and carers for challenging the Trust to become even better, John said it was a privilege to serve the people within CNTW patch and it had been an honour to be Chief Executive with 8,500 wonderful people.

Resolved:

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

7. Chief Executive's Report

John Lawlor referred to the report noting that discussions had commenced with staff, stakeholders, service users and carers to review to Trust's strategy, known as CNTW2030.

John noted that ReCoCo, Newcastle Recovery College had been shortlisted for the Bright Ideas in Health award in "Helping our workforce to recover from the pandemic" category.

John confirmed Sam Allen had been appointed as Chief Executive of the North East and North Cumbria Integrated Care System. Across the country appointments have been made

to 28 of the 42 Integrated Care Systems, with eight still to make an announcement and a further six failing to appoint.

Resolved:

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

Quality, Clinical and Patient Issues

8. COVID-19 Response update

Gary O'Hare updated the Board. At the time of the meeting the Trust was reporting 13 positive patients in wards, three inpatient outbreaks, with a further two outbreaks still to be confirmed. Over the previous seven days there has been a further 23 staff testing COVID positive, but overall sickness levels have started to reduce.

In relation to first dose vaccinations 95.2% of staff how now received their first vaccine and 94% received their first and second dose. 77.8% who have already received both vaccinations are eligible to receive their booster vaccination with an overall total of all staff 67.9% having already received their booster. Gary stated that many staff have taken the opportunity to have both booster and flu at the same time however some staff have opted to attend the dedicated flu drop-in sessions or attend their own GP/Pharmacy. Approximately 57% of staff have received the flu vaccination.

Gary advised the NHS was now dealing with the South African Variant 'Omicron' with the government reinstating some restrictions from the 30 November 2021. The Trust has reviewed the internal restrictions for all staff in line with guidance.

Gary confirmed an Incident Management Group had been established to address the issues of unvaccinated staff with national guidance still awaited in relation to mandatory vaccinations.

Resolved:

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

9. Commissioning and Quality Assurance update (Month 7)

Lisa Quinn presented the report and noted the Trust remained assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework. Lisa advised that only 32 Trusts across the country have remained in segment 1 throughout the pandemic reflecting the continued strong operational performance across the Trust.

Four Mental Health Act Reviewer visits have taken place during the period to a range of services. There have been some areas of improvement identified and the Trust is following the usual process of reviewing those actions that have been noted in those areas.

Lisa highlighted a further deterioration in children services in terms of access and referred to a specific Board session looking at the increased demand for this service area.

Both Covid and non-Covid related sickness absence remained an area of concern with a further increase to 6.20% in the month.

James Duncan noted the Trust has a £0.7m surplus which is £0.2m ahead of plan. The plan for H2 is to deliver a break-even position. James highlighted income arrangements for H2 were a continuation of the block contracts implemented in 2020-21 in response to COVID. James confirmed the Trust was a Provider Collaborative lead in the North East and Cumbria for Specialist Children and Young People's Services (CYPS) services and Adult Secure services and as a result, the Trust will manage an additional £53m income and expenditure in 2021/22. James referred to capital spend £18.3m at Month,7 which was £9.1m less than plan and a forecast spend is £40.8m, which is £6.4m less than plan.

Lisa referred to the publication of the 2021 Community Mental Health Survey, which has been published on the CQC website. The report would be submitted to the February 2022 meeting of the Board. Lisa reported a 26% response rate across the country to the survey with three organisations having a score of better than expected during the period. Lisa mentioned in terms of CNTWs overall results a response rate of 28% which is slightly higher than national average.

Darren Best referred to the Mental Health Act Reviewer visits, noting that themes are reported to the CQC Compliance Group and the Mental Health Legislation Sub-Committee but asked if any of the themes should be reviewed at Board level. Lisa referred to two common themes relating to staffing issues and delayed transfers of care into more appropriate services. The Committee Chair's have been engaged in a review of the process going forward which will include an annual report to the Board on issues highlighted by regulatory visits.

Resolved:

- **The Board received the Month 7 Commissioning and Quality Assurance update**

Workforce Issues

10. Workforce Report – Quarter 2

Lynne Shaw referred to the report and highlighted the Trust had submitted to the Stonewall Index at the start of October 2021. Lynne mentioned the Inclusive Monitoring is one of the ways by which the Trust are strengthening engagement and the first pilot is ready to commence.

Lynne referred to Disability History Month, which runs throughout November to December noting several events planned. Lynne advised that the Trust had signed up to 'Purple Space' for a period of twelve months, a disability-led organisation that helps disabled staff networks connect and share knowledge with a world-wide disability employee network of networks.

From an Adult Healthcare Professional perspective, a programme has commenced to pilot and evaluate the NHS Leadership Academy's refreshed Edward Jenner Programme (EJP) with a cohort of 43 self-selected AHPs who have identified as needing some further leadership and management development.

From a health and well-being perspective the Trust 'Thrive' website was launched on 4th October and Lynne mentioned the excellent work undertaken from the Workforce Development Team and Communications Team on the development of the external website

and branding which will promote staff health and wellbeing as well as other areas such as reward and retention. Lynne mentioned the launch of the health and wellbeing steering group to commence in October which will bring together different strands of health and wellbeing moving forward.

Lynne confirmed a paragraph on exit questionnaire data had now been included within the report. The Trust completion rate for questionnaires has reduced over the last two years and within the last quarter stood at 13%. Lynne advised that retirement was the most frequent reason for staff leaving but there has also been an increase of staff leaving to join other organisations for improved work-life balance and career progression.

Peter Studd asked for an update on the roll out of the appraisal and staff personal development plan process. Lynne confirmed the new appraisal process was rolled out in April 2021 and now in place, the training has been ongoing since March. The process was being adapted following feedback from across the organisation.

Darren Best referred to the Thrive website being an excellent initiative but was concerned, through discussions with the health and wellbeing team, that the website is not being used and accessed in the numbers which was hoped. This was due to capacity of people to be able to access information and the time to be able to do it. Darren also emphasised the importance of variance across the Trust that managers place on health and wellbeing.

Resolved:

- **The Board received the Quarterly Staff Survey Report**

11. Workforce Planning update

Lynne Shaw referred to the Trust's internal planning process to incorporate the deliverables set out in both the Long-Term Plan and People Plan. Workforce planning is identified as a priority within the NHS People Plan in supporting the sustainability and delivery of future services. Prioritising workforce plans as part of the CNTW Planning Approach will help better understand workforce gaps, training needs and upskilling, succession planning and ultimately improve health and wellbeing and retention of staff. These plans will also inform regional and ICS workforce planning.

Resolved:

- **The Board received the Workforce Planning update report**

Strategy and Partnerships

None to note.

Regulatory Items

12. CNTW Submission for H2 Planning

James Duncan referred to the enclosed paper for information.

Resolved:

- **The Board received CNTW submission for H2 Planning**

13. Monkwearmouth Business Case

James Duncan referred to the business case outlining proposals to address long-standing structural issues comprising of the original 90-year-old Monkwearmouth Hospital building. Potential options have been considered to redevelop the site taking into consideration the long-standing association with healthcare provision, good access to transport links and a good location for the types of services provided for the people of Sunderland and South Tyneside.

James highlighted the recommendations, which are outlined with the full business case, noting the preferred recommendation to demolish the existing building and replace with a fit for purpose facility under the developer led framework. He also updated the Board that the planning application for the development had been turned down, but the, pending Board approval, an appeal would be submitted that the Trust and its advisors were confident it would win.

Resolved:

- **The Board received and formally approved Monkwearmouth Business Case**

Board sub-committee minutes and Governor issues for information

14. Quality and Performance Committee

No meetings have taken place since the November Board meeting.

15. Audit Committee

No meetings have taken place since the November Board meeting.

16. Resource and Business Assurance Committee

No meetings have taken place since the November Board meeting. Ken Jarrold confirmed Paula Breen, Non-Executive Director will be taking over as Chair of RABAC and will present the next report in February 2022.

17. Mental Health Legislation Committee

No meetings have taken place since the November Board meeting.

18. Provider Collaborative Committee and Terms of Reference

No meetings have taken place since the November Board meeting.

19. CEDAR Programme Board

Peter Studd advised the Board the development in relation to Ferndene would be further delayed potentially up to 10-12 weeks after finding roof defects in the original build with Laing O'Rourke admitting liability. It was noted that the delay does provide an opportunity to undertake overdue maintenance work with additional decoration, moving and replacing of flooring and doors.

Peter referred to the land sale which is going well with strong offers being submitted. A paper will be provided to the CEDAR Programme Board in January 2022 and a paper to follow at Closed Board in April 2022 on the recommended bidder for the land sale.

20. Charitable Funds Committee

Paula Breen noted that Louise Nelson, Non-Executive Director will be taking over a Chair of Charitable Funds Committee.

21. Council of Governors issues

Ken Jarrold noted that Council of Governor Elections were underway with three contested elections. A full report will be provided to the Board and Council when the detail is available.

Ken referred to the Joint Board of Directors and Council of Governors meeting due to take place on 10th December 2021, given the enormity of the challenges within the Trust a detailed update will be provided on current pressures within the Trust and NHS.

Two Non-Executive Directors term of office come to an end in January 2022, therefore the Nomination Committee will be considering their re-appointment. An update will be provided at a future meeting.

22. Any Other Business

None to note.

23. Questions from the public

There were no questions from the public.

Date and time of next meeting

Wednesday, 3 February 2022, 1.30pm venue, Microsoft Teams.

Board of Directors Meeting held in public

Action Log as at 2 February 2022

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

Item No.	Item	Action	By Whom	By When	Update/Comments
Actions outstanding					
01.12.21 (5)	Committee reporting	Clarification regarding which workforce-related reports are statutory and non-statutory – to be reported into the People Committee	Lynne Shaw	March 2022	
04.08.21 (21)	North Cumbria PALs service	Provide an update on progress to establish a PALs service across the Trust footprint	James Duncan	April 2022	On track
Completed Actions					
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	Complete	Agenda item for the Joint Council of Governors and Board of Directors meeting
03.11.21 (32)	Any other business	Circulate the briefing provided by Evelyn Bitcon to Board members and Governors	Debbie Henderson	Complete	Circulated via email
01.09.21 (13)	Quarterly workforce report	Themes from exit interviews to be included in future reports	Lynne Shaw	December 2021	Complete.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting
Chief Executive's Report
Wednesday 2nd February 2022

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

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

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

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

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

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

Meeting of the Board of Directors
Chief Executive's Report
Wednesday 2nd February 2022

Trust Updates

Annual Planning 2022/23

We are setting out our priorities for the next financial year, based on continuing current programmes of work and stabilising our position. National guidance has clarified financial arrangements and sets expectations about priorities at system level, helping us to evaluate any potential impact of delivering national priorities on our core services, given our workforce pressures. System level planning requires a number of returns to be submitted to the Integrated Care System (ICS) over the next few months and we are taking care to ensure that we see these submissions as stops along a continuous integrated planning journey, rather than the destination.

Key principles underpinning the national planning priorities for 2022/23 are based on an assumption that COVID-19 returns to a low level and Trusts are able to make significant progress in the first part of 2022/23 in restoring services and reducing COVID backlogs, while also:

- Prioritising the support for the health and wellbeing of staff.
- Accelerating plans to grow the workforce.
- Embedding learning from the pandemic including adopting new models of care.
- Moving back to and beyond pre pandemic levels of productivity.

Northumberland Community Learning Disability Nursing Service

Following a review by Northumberland Clinical Commissioning Group (CCG) of its Community Learning Disability pathway, Cumbria, Northumberland, Tyne and Wear NHSFT has been asked to consider taking over the contract for community learning disability nursing.

Following the dissolution of a section 75 partnership agreement between Northumberland County Council and a neighbouring Foundation Trust, the CCG, with the agreement of all parties, undertook a review of its learning disability pathway. The review made the following recommendation: *To achieve a safe, sustainable, and integrated community learning disability service in Northumberland the NHS commissioned community learning disabilities pathway should be delivered by a single organisation.*

Being one of the existing providers of learning disability services in Northumberland, the Trust has now received a written request to consider taking on the contract for community nursing in Northumberland, thus leading to a single provider model for the health element of the learning disability pathway. This contract amounts to circa £1m existing service (circa

23 staff) and the offer of further investment in this pathway. The North Group along with the Executive team will work with commissioning colleagues, Local Authority and the existing provider on the proposed pathway consolidation. A paper is due to be considered by the Executive Team on the offer put forward by the commissioning group.

Update on developments of Nursing research – joint appointments, joint working

Work with Northumbria University.

CNTW has made a joint appointment with Northumbria University of an Associate Professor of Nursing to develop the nursing research culture within the Trust. Nicola Clibbens will commence this joint appointment role in January 2022. Additionally, an existing Professor of Nursing, Geoff Dickens (also from Northumbria University) will work alongside Nicola on a part-time secondment basis into CNTW. Managed jointly between the Trust and the University, these two individuals will help shape our priorities and create nursing pathways into research at all levels to meet the needs of the organisation at clinical, operational and organisational level.

Work with University of Sunderland

Although less formal, work has progressed over the past seven months to create an informal network of communications/practical experiences between the Trust and University of Sunderland, examples include small, funded internships and joining up interested parties with academic mentors (and vice versa) to 'test out' an area of work to see if it feels right for an individual without making any firm decisions. This is particularly useful for CNTW staff who may be interested in research but who do not have the necessary qualifications to make a firm career move and/or those who do not wish to leave clinical practice.

The nursing research developments will be managed within the portfolio of the Deputy Director of Nursing, accountable to the Chief Nurse.

Both approaches feed into the Trust Nursing Strategy, the Trust Research Strategy and the newly emerging Chief Nursing Officer Strategic Plan for Research.

National updates

Health checks for people with Severe Mental Illness and/or a Learning Disability

NHS England & Improvement circulated a letter calling on the wider health and care system to work flexibly with primary care colleagues to support the delivery of health checks for people with Severe Mental Illness and/or a Learning Disability over the remainder of this financial year. The letter outlines possible approaches including increasing capacity within mental health trusts to deliver physical health checks for SMI patients they have had contact with. Systems are being asked to draw on current underspends to fund this additional capacity, and to work with NHSEI regional finance leads to draw down additional central funding where no underspend is available.

Primary care colleagues have been asked to work with commissioners to prioritise checks based on clinical risk and accounting for inequalities. The letter highlights physical health checks for these groups as a key priority alongside the Covid-19 booster rollout.

Mark Winstanley, CEO of Rethink Mental Illness published an article in the HSJ supporting the 'blitz' on health checks for people with Severe Mental Illness and highlighting the role of the VCSE sector in supporting delivery. The article suggests that people with SMI die 15 to 20 years earlier than the rest of the population and that the mortality gap is growing, in part due to the impact of the pandemic. The percentage of people with a Severe Mental Illness receiving an annual health check has not risen above 36% since the Five Year Forward View was published in 2016, falling far short of the 60% target set. Winstanley shares examples of best practice and communications resources for supporting both staff and patients to improve the uptake of health checks.

Reducing inequalities in access to care

Analysis of elective waiting lists by Calderdale and Huddersfield FT found that in May 2021 patients from an ethnic minority background were waiting an average of 7.8 weeks longer than white patients for elective surgery, with patients from the most deprived areas waiting an average of 8.5 weeks longer than patients from the least deprived areas. Intelligence from the study enabled the Trust to significantly reduce inequalities in waiting times over the course of 2021; by October the gap in average waiting times between ethnic minority and white patients was reduced to three weeks, with the gap in average waiting times between patients from the most and least deprived areas reduced to 2.5 weeks. Owen Williams, former CEO of Calderdale and Huddersfield and now Chair of NHSE/I's Inequalities Expert Advisory Group suggested Trust Boards must be proactive in undertaking similar analyses to address inequalities.

Revised ICS development timeline

NHSE/I published an updated version of the Integrated Care Board (ICB) establishment timeline designed to support systems to develop their local ICB establishment programme plans in response to the announcement that the implementation of statutory ICSs has been delayed from 1 April to 1 July to allow for the passage of legislation. Key milestones from the revised timeline include:

ICB appointments

- 31 March: Appoint remaining designate ICB chairs, chief executives, non-executive directors and all other ICB executive board level posts
- 29 April: Appoint designate partner members to ICB board

ICB constitution

- 31 January: NHSE/I will publish the updated draft model constitution and functions and governance guide. This will be updated again by 11 March and 13 May.
- 31 January: Submit updated draft ICB constitution for review by the NHSE/I regional team
- 20 May: Submit final draft ICB constitution for final review from the NHSE/I regional team prior to regional director approval

Other elements of ICB readiness

- 31 January: NHSE/I to release financial objectives and requirements on ICBs in draft form, and joint capital resource plan
- 31 March: Provider partnership arrangements, which will apply from 1 July 2022, to be agreed in line with relevant guidance
- 31 March: ICB leadership model / arrangements to be prepared in line with relevant guidance
- 31 March: Arrangements for system oversight in 2022/23 between NHSE/I regional teams and the ICB to be prepared
- 31 March: ICB functions and decision map to be prepared, including place-based leadership, governance and delegations (where appropriate)
- 27 May: Document joint commissioning arrangements for 2022/23

Integrated Care Partnership (ICP) arrangements

31 March: Agree initial ICP arrangements, including principles for operation from 1 July 2022

Improving the mental wellbeing of 8-13 year olds

Centre for Mental Health published *Everyday Magic*, a briefing summarising learning at the halfway point of BBC Children in Need's A Million and Me programme. A Million and Me is a £10m 3-year programme which aims to improve the mental wellbeing of 8-13 year olds and their families as well as generating learning to influence systems. The report suggests that the mental health of children in the 8-13 cohort has been overlooked and that investment in support and resources for children and adults will produce significant benefits, based on learning from the first two years of the A Million and Me programme.

The report highlights:

- the value placed by children in the 8-13 cohort on positive, rewarding relationships with adults and peers, which help them to make sense of their own mental health
- the value of everyday conversations about mental health which happen within these relationships, and the importance of appropriate resources to support those conversations

The report makes several recommendations including:

- Partnership working between statutory organisations and the voluntary sector, families and schools to deliver a more consistent, relationship-driven approach to supporting children's mental wellbeing
- The provision of training and resources for the wider children's workforce, including the voluntary sector, to increase capability in relation to having good-quality conversations about mental wellbeing
- A focus on addressing inequality in children's mental wellbeing e.g. disabled children, children with behavioural difficulties, children living in rural and coastal communities, and children living in poverty

NHS England and Improvement launch national *Help!* campaign

NHS England & Improvement launched a national mental health campaign called *Help!* promoting the benefits of talking therapies and encouraging the public to seek mental health support if they are struggling, citing figures released this week that more than 50% of people were concerned about their mental health last year. In response, Sean Duggan, Chief Executive of **NHS Confederation's Mental Health Network** acknowledged the role of talking therapies but called on the Government to 'go further in its acknowledgement of the increased demands placed on mental health services as a result of the pandemic and invest accordingly' highlighting the impact of increasing demand for mental health support on all parts of the health and care system, with around one third of primary care work focused on supporting people with mental health problems.

Regional Updates

NENC ICS Constitution consultation

The NENC ICS Integrated Care Board draft Constitution has been published for consultation. The constitution must be proposed by the governing body of each Clinical Commissioning Group (CCG) in the North East and North Cumbria (NENC) area before being submitted to NHSEI for approval. The Constitution sets out plans for the membership and governance of the ICB. Proposals include representation from two Foundation Trusts, four Local Authorities and two GP providers, in addition to the Chair, Chief Executive, and both Executive and non-Executive Director roles currently being recruited to. While the draft Constitution proposes a collective model of decision-making based on consensus, it outlines the voting process to be followed as a last resort where consensus cannot be reached.

NENC ICS Health Inequalities Advisory Group progress update

North East and North Cumbria ICS Health Inequalities Advisory Group circulated an update to partners outlining progress against the ICS ambitions in this area which are raising healthy life expectancy and halving the gap between the average healthy life expectancy across the ICS footprint and the average healthy life expectancy for England. The governance arrangements for this work continue to develop, with new groups established to support the embedding of a health inequalities approach across ICS workstreams including workforce development. The scale of health inequalities across the ICS footprint and addressing these in the context of the existing pressures facing the health and care system and its workforce are highlighted as key challenges to the delivery of the ICS ambitions in this area. Following discussion with CNTW's Executive Team, we are committed to supporting a dedicated session of the Board in the future to explore the Trust's role in addressing health inequalities.

James Duncan
Chief Executive
February 2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
Wednesday 2nd February 2022

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

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

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

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

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

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

Coronavirus (COVID-19)
Report for the Board of Directors meeting
Wednesday 2nd February 2022

1. Executive Summary

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

- Covid–19 Prevalence, Surge and Business Continuity
- Nosocomial & Outbreak Management
- Mandatory Vaccination update

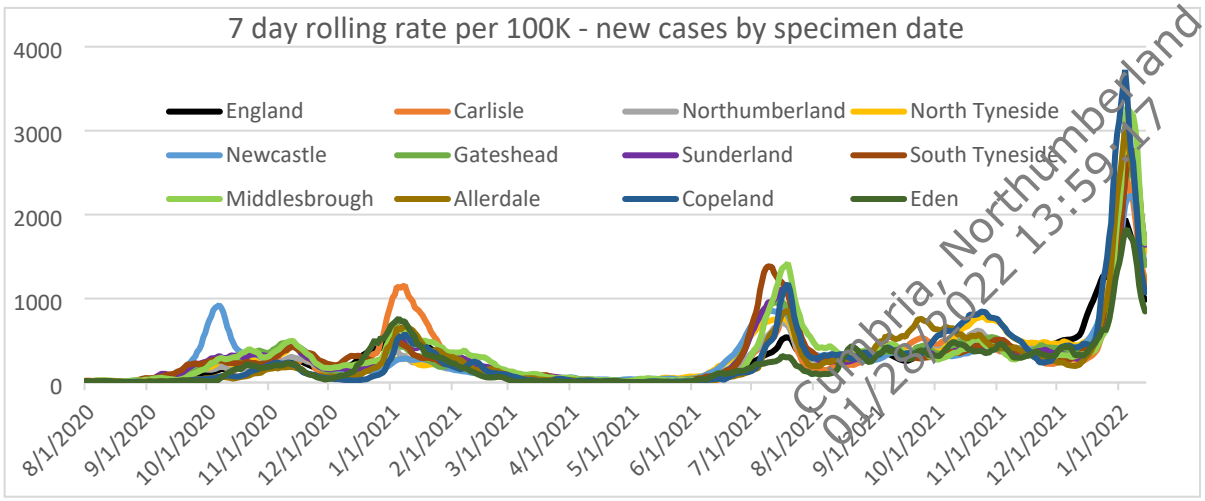
2. Covid–19 Prevalence, Surge and Business Continuity

Following the report to December Trust board which showed a settled picture, members will be aware that shortly after this the UKHSA notified organisations that the country was moving rapidly to a Level 4 National Incident based on South East rates of the new Omicron variant.

- The UK rate doubled every two days – phenomenal / rapid increase in variant. Mainly in London and South East, and as predicted moved across the country within the next eight days.
- Two epidemics were being experienced at once – Delta and Omicron – the latter now dominant.
- Highly transmissible, cold like symptoms, overall, less severe illness but unpredictable.
- Numbers were projected to lead to overloading of NHS Services and our aim was to protect and minimise.

2.1 North East and Cumbria (NE&C)

The North East and Cumbria localities and overall Trust position was at that time stable, but this changed radically with a massive increase in cases in the week prior to Christmas and New Year, linked to close contact and social gatherings across the communities in the NE&C. The positivity rates far exceeded previous peaks experienced throughout the pandemic and CNTW staff absence and then patient transmission surged suddenly over the next three weeks.



3. Summary of Actions taken to respond to the unprecedented surge

3.1 Tactical response

- Gold Command was enhanced and stood back-up.
- Covid Incident Management Group increased to three times per week.
- Additional support to Absence line Call handling pressures.
- Staff risk assessment and Health and Wellbeing support.
- Increased Outbreak management response.
- Review and implementation of changing national guidance.
- Moved to OPEL level 3.

3.2 Staff

To support rapid testing and return to work safely:

- Additional PCR Testing – three sites: SNH, HWP, Carleton Clinic; home visits and extended hours
- Additional LFD devices for staff.
- Enhanced Standard Infection control measures at ward and clinical team level to prevent patient transmission.
- Potential risk that FRSM masks not fully protecting staff and patients and moved to FFP3.
- Continuing to PCR test all staff in close contact or positive LFD – no change to Trust guidance.

3.3 Patients

To ensure early detection and prevent transmission:

- Changed visiting guidance to ensure negative LFD in additional to welfare checks for booked visit slots.
- Increased outbreak support and Test and Trace positive risk assessment.
- Patient leave risk assessed and advice re IPC measures and Personal protective behaviour / patients encouraged to wear face masks on ward and social distance / hand washing.
- PCR screening on admission / return from leave and routine seven day surveillance.
- FFP3 masks were introduced for all staff who could be fit tested, as an enhanced safety measure for the duration of the outbreak.

3.4 Impact of the Surge Response

Despite the measures taken above we saw a rapid increase in positive households, staff, and patients positive over the initial two week period:

- 950 staff tested positive over the 4 week period.
- 56 positive patient cases in our inpatient settings.
- 15 outbreak areas.

4. Nosocomial and Outbreak Management

CNTW currently has 15 outbreaks which reflects the amount of community prevalence and is mirrored across most trusts in the NE&C. All outbreaks must be 28 days free without a further positive case linked in time and place before it can be closed.

4.1 Learning themes from Outbreak areas:

- Patients positive on admission from the community.
- Nosocomial spread has been linked to positive patients unable to comply with isolation / mixing with other patients / close contact and unable to socially distance and wear face masks resulting in transmission between patients.
- Incorrect Doffing – IPC staff have supported wards including domestic staff and positive feedback received.
- Poorly ventilated areas- especially in older people services where windows have been closed to ensure patient comfort and temperature control is more difficult in the colder weather
- Staff uptake of twice weekly LFTs noted as low and lack of recording results on CNTW portal identified in most outbreak areas.
- Lack of lidded bins noted in some of the outbreak areas.
- Staff coming into work whilst symptomatic.
- Staff not wearing / washing bare below elbow and general handwashing.

4.2 New and stabilising Outbreaks

Mowbray: Day 8 Mowbray is a large outbreak involving nine patients and 14 staff. The environment is challenging, and it is difficult to maintain social distancing and many patients require personal care and have close contact with each other. Large number of staff absent from work due to positive test result, impacting on service continuity.

Rose lodge: Day 8 involves five patients and three staff. Several incidents requiring PMVA response noted - masks were worn.

Cleadon: Day 5 involves four patients and two staff. Nosocomial transmission. Communal activities in dining area and difficult to socially distance. Patients have close contact.

Yewdale: Day 9 involves two patients and one staff member. Nosocomial transmission and likely cause of transmission based on Patient A and Patient B have bedrooms next door to each other and potential of cross transmission. Further group activities and car journeys to be reviewed.

Ward 4, WGP: Day 7 involves one patient and two staff. Community patient transmission. Staff worked together and cared for patient. Both staff described incorrect doffing procedure.

Alnmouth: Day 9 Alnmouth was a large outbreak involving nine patients and five staff. All patients are out of isolation now and doing well. Staff are returning to work, easing service continuity pressures.

4.3 Outbreaks in Recovery

These outbreak areas are in recovery and patients are now out of isolation and usual ward practices resumed including leaves and visiting. Focus is on embedding IPC practice and continued close monitoring and visibility of senior leadership team.

Riding: Day 14
Bede: Day14
Shoredrift: Day 12
Hauxley: Day14
Roker: Day 15
Beckfield: Day 15

4.4 Dormant Outbreaks

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

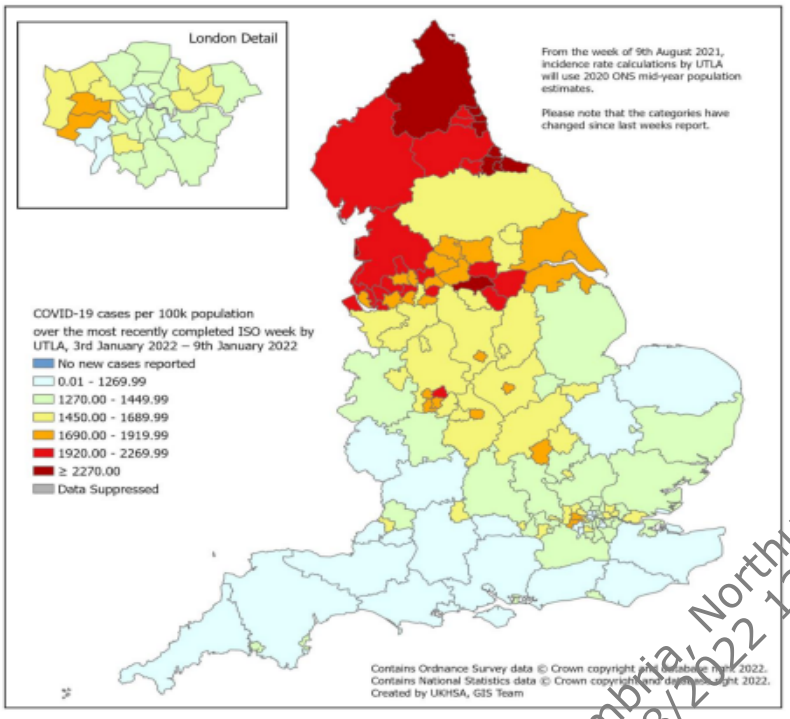
Ashby: Day 26
Lotus: Day 24
Akenside: Day 22

5. Moving forward

It is important for Board members to note that the overall prevalence rates across our footprint remain equivalent to the position in January 2021. The North East continues to have high rates week ending 9th January and remains at risk of further surge activity as the move to Plan A and removing restrictions from Plan B at the end of January.

Figure 1

Figure 10: Weekly rate of COVID-19 cases per 100,000 population (Pillar 1 and 2), by upper-tier local authority, England (box shows enlarged map of London area)



6. Update on return to work following change in guidance for COVID-19 contacts

The last report outlined our response to guidance which enabled Trusts to review case by case and return Health Staff from isolation to work if a close contact

identified by the NHS Test and Trace App or a close contact which was non-household.

Since the last meeting there has been rapid guidance changes for the public and then Health care staff which have been promptly implemented for all staff

- All staff who have been double vaccinated, have been a close contact non-household / T&T / NHSApp have a PCR and undertake daily lateral flows and do not now need to isolate – resulting in rapid return into workplace.

- Household close contacts who have been double vaccinated must isolate until negative PCR then daily LFD, and repeat PCR at day five.

- Positive staff must isolate and can begin LFDs at Day five and if they have a consecutive negative test 24hrs later can now return to the workplace.

- Anyone who is partially or not double vaccinated must continue to isolate for ten days.

The screening process has resulted in the successful return of staff to the workplace. There have been no patient safety breaches i.e. transmission linked to any outbreak area, and no staff to patient or staff to staff transmission from any staff members returned through this process. We have no exclusion areas, although a risk assessment for anyone returning to work in an area with CEV patients is discussed with line managers.

It is proposed that we continue with the rigorous CNTW Test and Trace process which will be rigorously monitored and any cases of staff to patient transmission or link to outbreaks in these vulnerable groups the process will stop and be subject to review.

7. Government announcement on consultation on mandatory vaccinations for Health and Social Care Staff

As reported at the last report, the Department of Health and Social Care (DHSC) formally announced on the 9th November 2021 that individuals undertaking CQC regulated activities in England must be fully vaccinated against Covid-19 no later than 1st April 2022 to protect patients, regardless of their employer, including secondary and primary care.

- Draft Regulations were made law on 6th January 2022.
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No. 2) Regulations 2022 came into force on 7th January 2022.
- 12 week grace period, come into force on 1st April 2022.

An Incident Management Group (IMG) has continued to lead the workplan and considered the posts which are “in scope”

- Engaged with trade unions, staff network chairs, FTSU Guardian, managers and staff.
- Sent out Trustwide communication advising of the pending changes to legislation.
- Wrote to all staff who do not have two doses recorded onto the national system.
- Supportive 1:1 discussion with line managers (ongoing).

- Confidential pharmacy help line.
- Increased vaccination clinics.
- Central mailbox to capture feedback and respond to queries.
- Equality Impact Assessment (in draft).
- Amended adverts, etc, to reflect the regulatory changes.

8. Recommendation

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

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

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
2nd February 2022

Title of report	**CNTW Integrated Commissioning & Quality Assurance Report**
Report author(s)	**Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of 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	26.01.2022
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	24.01.2022
Corporate Decisions Team (CDT)	
CDT – Quality & Safety	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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

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

CNTW Integrated Commissioning & Quality Assurance Report 2021-22 Month 9 (December 2021)

Executive Summary

Regulatory Requirement

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

2 At Month 9, the Trust has a surplus of £0.4m which is £0.2m ahead of plan and the forecast year-end position is breakeven which is in line with plan. Agency spend at Month 9 is £14.8m of which £9.4m (64%) relates to nursing support staff and forecast agency spend is £19.9m.

3 The Data Quality Maturity Index (DQMI) score is reported at 93.7% for September which is the latest published data available. The DQMI publication includes data from a number of datasets relevant to the Trust. The DQMI score relating to the Mental Health Services Dataset (MHSDS) only is reported at 92.7% for CNTW.

4 Information Governance training is reported at 87.9% at the end of December 2021 against a 95% standard across CNTW services.

5 There were 120 inappropriate adult out of area bed days due to the unavailability of adult acute and adult older persons beds reported in December 2021. This related to ten patients.

6 In Sunderland IAPT service, percentage of clients moving to recovery has decreased during the month and is reported at 55.7%, 62.0% in November 2021. The North Cumbria IAPT service moving to recovery rate has increased to 49.8% for the month, 48.7% in November. The national standard is 50%.

7 At month 9, 92.1% of referrals to Early Intervention in Psychosis (EIP) started treatment within 2 weeks of referral against a 60% standard.

8 The number of follow up contacts conducted within 72 hours is reported above the 80% standard at 88.9% across CNTW. A total of 13 patients were not seen within the required timescale trust wide.

9 Referral to treatment (RTT) incomplete pathways for consultant led services waiting 18 weeks or less are reported at 100%.

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

- Waiting times for routine referrals (seen within 4 weeks) at Quarter 3 is reported at 71.2% (87.0% national reported data)

- Waiting times for urgent referrals (seen within 1 week) at Quarter 3 is reported at 100% (87.5% national reported data).

11 There has been two Mental Health Act Reviewer visits since the last report to Bede and Newton ward. Feedback from the visit includes consent/authorisation of medication, delayed transfers of care, staffing issues impacting on ward activities, seclusion/long-term segregation and blanket restrictions.

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

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

Contractual Requirement

1 The Trust met all local CCG's contract requirements for month 9 and Quarter 3 with the exception of:

- CPA metrics for all CCGs with the exception of Sunderland.
- Delayed Transfers of Care within South Tyneside, Durham and Tees and North Cumbria.
- Valid ethnicity completed MHSDS only in North Tyneside.
- 72 hour follow up in the month for North Tyneside but achieved for Quarter 3.
- IAPT numbers entering treatment in Sunderland and North Cumbria.

2 The Trust met all the requirements for month 9 and Quarter 3 within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (93.1% against a 100% target).

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

4 The overall FFT satisfaction score for December 2021 was reported at 92.7%, this was based on the number of responses received from service users and carers who stated their overall experience with CNTW services was either good or very good. The number of Points of You survey returns received was 153, of which 80% were from service users, 8% from carers and 12% were completed on behalf of a service user.

Internal Reporting

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

As at 31st December 2021 there were a total of 140 people waiting more than 18 weeks to access services in non-specialised adult services across CNTW. This is an increase from 101 reported in November.

2 CYPS waiting times from referral to treatment are reported in line with the national definition. The wait to treatment is calculated from referral received date to second contact and both contacts can be either direct (e.g. face to face, telephone) or indirect contacts (e.g. Multi-Disciplinary meeting or discussion with another care professional).

This month there has been an increase in the total number of CYP waiting more than 18 weeks to treatment, reported at 1553 as at 31st December 2021 compared to 1454 as at 30th November 2021. The number of young people waiting to access children's community services overall has increased in month 9.

3 Training topics below the required trust trajectory as at month 9 are listed below:

Training Topic	Month 9 position	Quarter 3 trajectory	Quarter 3 standard
Information Governance	87.9%		95%
PMVA Breakaway training	70.7%	83%	
Mental Health Act combined	65.7%	75%	
Clinical Risk and Suicide Prevention training	80.7%	84%	
Clinical Supervision	78.8%	83%	
Seclusion training	68.9%	84%	
Rapid Tranquilisation	78.8%	85%	
Safeguarding Children Level 2	79.1%	84%	
Safeguarding Children Level 3 **For completion by all professionally registered staff*	79.3%	80%	
PMVA Basic training	45.5%	61%	
Fire Training	82.4%	85%	
MHCT Clustering	58.8%		85%

4 Appraisal rates are reported at 69.0% in December 2021 (69.6% last month), the recovery trajectory for Quarter 3 is 80% Trustwide.

5 Clinical supervision training is reported at 43.5% for December (was 76.6% last month), showing a decreased position to the recovery trajectory of 84% for Quarter 3. The percentage of staff with a completed clinical supervision record is reported at 51.4% as at 30th November 2021. At 31st December 2021 the proportion of staff with a

management supervision recorded in the last 3 months is reported at 52.5% against a recovery trajectory of 79% for Quarter 3 2021.

6 The confirmed November 2021 sickness figure is 7.7%. This was provisionally reported as 7.88% in last month's report. The provisional December 2021 sickness figure is 8.10% which is above the 5% standard. The 12 month rolling average sickness rate has increased to 6.51% in the month.

7 The quality priorities at Quarter 3 have been internally assessed as:

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

Other Reporting

1 There are currently 17 notifications showing within the NHS Model Hospital site for the Trust.

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

During April, each of the locality groups and corporate services set 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 3 for Training and Quality Trajectories for 2021 – 2022

From Month 01 the Board report monitored against the agreed trajectories rather than the overall standard. Please note, the Trust recommenced managing against the trajectories from 1st October 2021 (Quarter 3) which were reviewed for recovery post COVID within the Locality Care Groups and updated for Quarter 3 and 4.

Please note from 5th January 2022 the Trust moved to OPEL Level 3 and stood down the performance management of training and appraisals with the exception of PMVA.

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	There has been two Mental Health Act Reviewer visits since the last report to Bede and Newton ward. Feedback from the visit includes consent/authorisation of medication, delayed transfers of care, staffing issues impacting on ward activities, seclusion/long-term segregation and blanket restrictions.

Contract

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

NHS England	Northumberland CCG	North Tyneside CCG	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	North Cumbria CCG
94%	90%	70%	80%	70%	93%	87%	50%

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

94%	90%	80%	80%	70%	93%	75%	50%

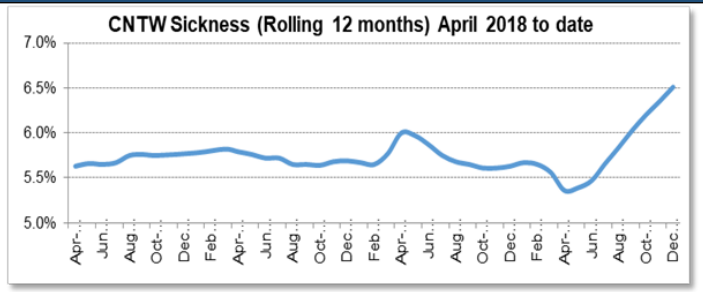
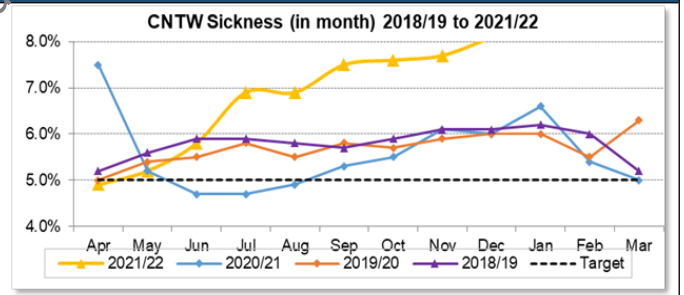
Contract Summary: Percentage of Quality Standards achieved in the month:

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									

Internal

Accountability Framework

North Locality Care Group Score: December 2021		Central Locality Care Group Score: December 2021		South Locality Care Group Score: December 2021		North Cumbria Locality Care Group Score: December 2021	
4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements

	Quality Priorities: Quarter 3 internal assessment RAG rating			
	Improving the inpatient experience	Improve waiting times for referrals to multidisciplinary teams	Increasing time staff are able to spend with service users and carers	Equality, Diversity & Inclusion and Human Rights
	Waiting Times			
	The number of people waiting more than 18 weeks to access services has increased in the month for non-specialised adult services and the number waiting for treatment has also increased. The number of young people waiting to access children's community services overall has increased in month 9. The number of young people waiting over 18 weeks has also increased. There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group have developed action plans which continue to be monitored via the Business Delivery Group and the Executive Management Team.			
Workforce	**Statutory & Essential Training:**			**Appraisals:**
	Number of courses Trajectory Achieved Trustwide:	Number of courses <5% below trajectory Trustwide:	Number of courses trajectory not achieved (>5% below standard):	Fire training (82.4%), Safeguarding Children Level 2 (79.1%), Safeguarding Children Level 3 (79.3%) Clinical Risk training (80.7%) and Clinical Supervision training (78.8%) are within 5% of the Quarter 3 trajectory. Rapid Tranquilisation training (78.8%), PMVA basic training (45.5%), PMVA Breakaway training (70.7%), MHA combined training (65.7%), MHCT Clustering Training (58.8%), Seclusion training (68.9%) and Information Governance (87.9%) are reported at more than 5% below the Quarter 3 trajectory.	Appraisal rates have decreased in the month to 69.0% in December 2021 (was 69.6% last month).
	7	5	7	
	Sickness Absence:			
		The provisional "in month" sickness absence rate is above the 5% target at 8.10% for December 2021 The rolling 12 month sickness average has increased to 6.51% in the month	
Finance	At Month 9, the Trust has a surplus of £0.4m which is £0.2m ahead of plan and the forecast year-end position is breakeven which is in line with plan. Agency spend at Month 9 is £14.8m of which £9.4m (64%) relates to nursing support staff and forecast agency spend is £19.9m.			

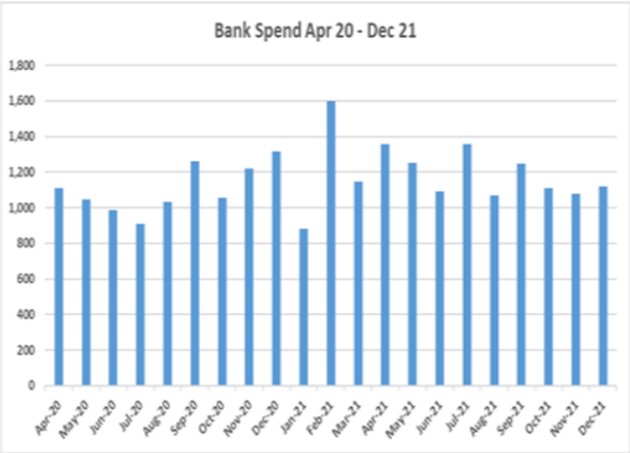
Financial Performance Dashboard

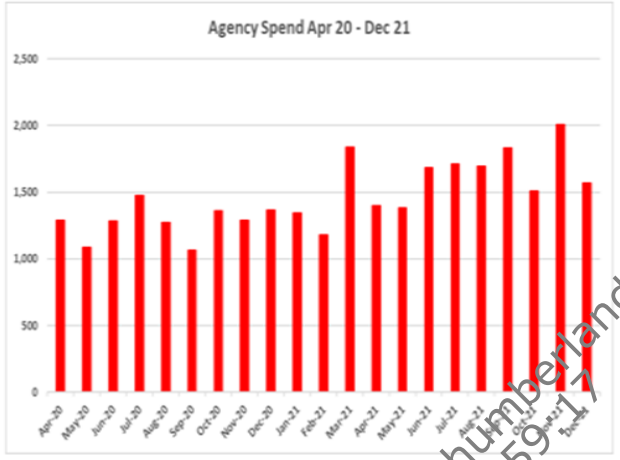
Income & Expenditure

	YTD			FORECAST		
	Plan £m	Actual £m	Variance (£)	Plan £m	Actual £m	Variance (£)
Income	368.6	375.2	(6.6)	495.2	514.6	(19.4)
Pay	(262.3)	(269.9)	7.6	(351.5)	(361.4)	10.0
Non Pay	(106.1)	(105.0)	(1.1)	(143.7)	(153.1)	9.4
Surplus / (Deficit)	**0.2**	**0.4**	**(0.2)**	**(0.0)**	**0.0**	**(0.0)**

Key Indicators

Key Indicators	Year To Date	Forecast
Surplus/ (Deficit)	£0.4m	£0.0m
Agency Spend	£14.8m	£19.9m
Cash	£73.6m	£50.0m
Capital Spend	£23.4m	£40.5m





Key Issues/Risks

- At month 9 the Trust has a £0.4m surplus which is £0.2m ahead of plan.
- The plan and forecast for the year is to deliver break-even.
- Income arrangements for H2 are a continuation of the block contracts implemented in 2020/21 in response to COVID.
- Staffing costs have increased in month 9 due mainly to a one-off recognition payment to all staff.
- The Trust is the Provider Collaborative lead for the North East & Cumbria for Specialist CYPs services and Adult Secure services. As a result the Trust is managing an additional £53m income and expenditure in 2021/22.
- Cash – £73.6m at month 9 which is more than historical cash levels (pre-COVID) due to improved working balances, capital spend being less than plan both this year and in 2020/21 and increases in provisions.
- Capital Spend - £23.4m at month 9 which is £11.8m less than plan. Forecast spend is £40.5m which is £6.8m less than plan. This mainly relates to the CEDAR project and the DHSC have agreed that the £6m related PDC funding allocated for 2021/22 will be provided in 2022/23.

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

	06/12/2021		13/12/2021		20/12/2021		27/12/2021	
Medical	120	72	120	72	120	72	124	76
Qual Nursing	163	61	151	95	177	125	100	69
Unq Nursing	1,552	133	1,585	97	1,413	97	1,317	63
A&C	34		57		62		24	
	1,869	**266**	**1,913**	**264**	**1,772**	**294**	**1,565**	**208**

In December the Trust reported an average of 258 price cap breaches (73 medical, 88 qualified nursing and 98 nursing support). At the end of December 16 medics were paid over the price cap.

Risks and Mitigations associated with the report

- There is a risk of non-compliance with CQC essential standards and the NHS Improvement Oversight Framework.
- The Trust did not meet all the commissioning standards across all local CCG's and NHS England at month 9 and quarter 3.
- The trust moved to OPEL Level 3 on the 5th January 2022, 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
18th January 2022	

Training Trajectories Quarter 2021-2022 – Appendix 1

Metric ID - Training Name	Standard	Q1						Q2					
		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.

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.

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%

		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%

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to Board
Wednesday 2nd February 2022

Title of report	**NHS Community Mental Health Service User Survey 2021 – Summary Report**
Report author(s)	**Paul Sams, Feedback & Outcomes Lead Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning & Quality Assurance**

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

Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance		Executive Team	31.01.22
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board		CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

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

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

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

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

NHS Community Mental Health Service User Survey 2021

Board Report

Wednesday 2nd February 2022

Executive Summary

This summary report shares the position of the Trust from the full table of results from the NHS Community Mental Health Service User Survey 2021. The position is based on the feedback in comparison with our own results in the 2020 survey as well as in comparison with the national average position of all Trusts who took part in the survey.

- The Trust received a response rate of 28.4%, above the overall rate of 26.5%
- The Trust has received responses that are better than the national scores in eight of the ten sections in the survey.
- The Trust was better than expected in 1 question
- The Trust was somewhat better than expected in 4 questions
- The Trust was about the same in 23 questions
- The Trust was no different in 17 questions
- The Trust was significantly worse in 8 questions
- In comparison with our own position in the 2020 survey, the Trust has performed less well in the 2021 survey on the majority of questions where a comparison is available. In most cases this is a marginal decrease.

The Trust will use this feedback along with our own internal feedback mechanisms to improve services and tailor quality priorities for the Trust ensuring views expressed are acted on.

Link to published surveys by Trust

https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2021/

National Position and Background

This paper is a discussion of the 2021 NHS Community Mental Health Survey. The survey is split into 10 sections, each of which will be discussed below. The report shows the Trust position against its own results last year and against the national results.

The 2021 survey of people who use community mental health services involved 54 providers of NHS community mental health services in England. Nationally responses were received from 17,322 people, a response rate of 26.5%.

Positive Results nationally include:

Organising Care – 90% of respondents felt the person organising their care did so ‘very well’ or ‘quite well’

Medicines – 63% of people who had received medicines in the previous 13 months ‘definitely’ had the purpose of receiving these medicines discussed.

Key areas for improvement nationally include:

Changes to care and treatment due to the pandemic have negatively impacted the mental health of many service users – 48% reported their mental health ‘got worse’ because of these changes.

Accessing Care – 42% of people said they waited ‘too long’ to access talking therapies.

Crisis Care- 49% of people said they ‘definitely’ got the help they needed. 20% said they did not get the help they needed when contacting a crisis service.

Headline Results for the Trust

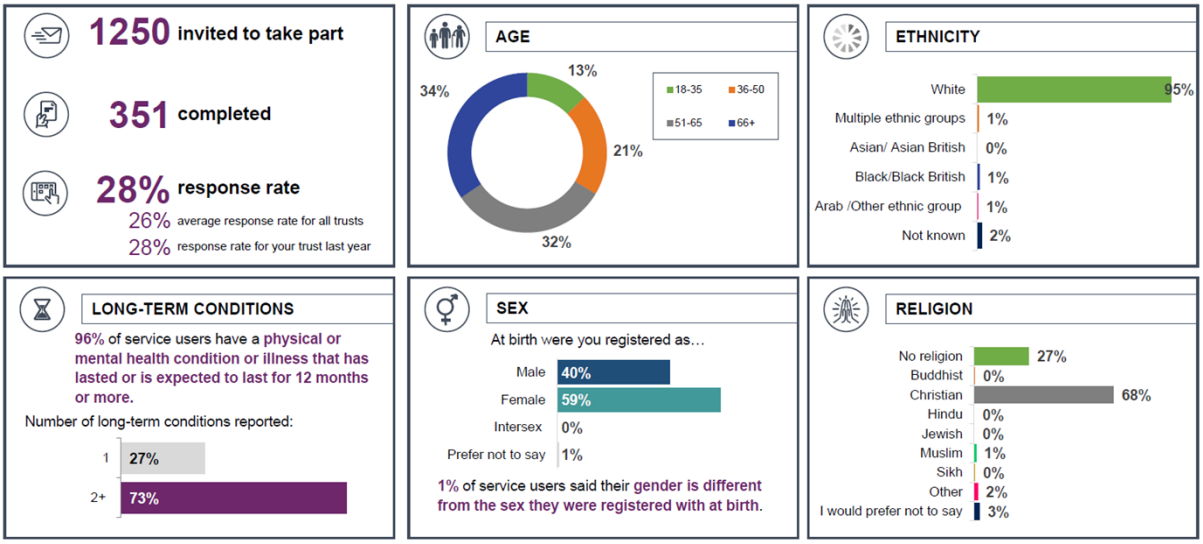


Figure 1. Who took part in the survey

The completion rate for people responding about the Trust was 28%, this is higher than the average nationally of 26%.

People between 18-35 years of age offered the least feedback (13%) and people over 66 contributed the most feedback (34%).

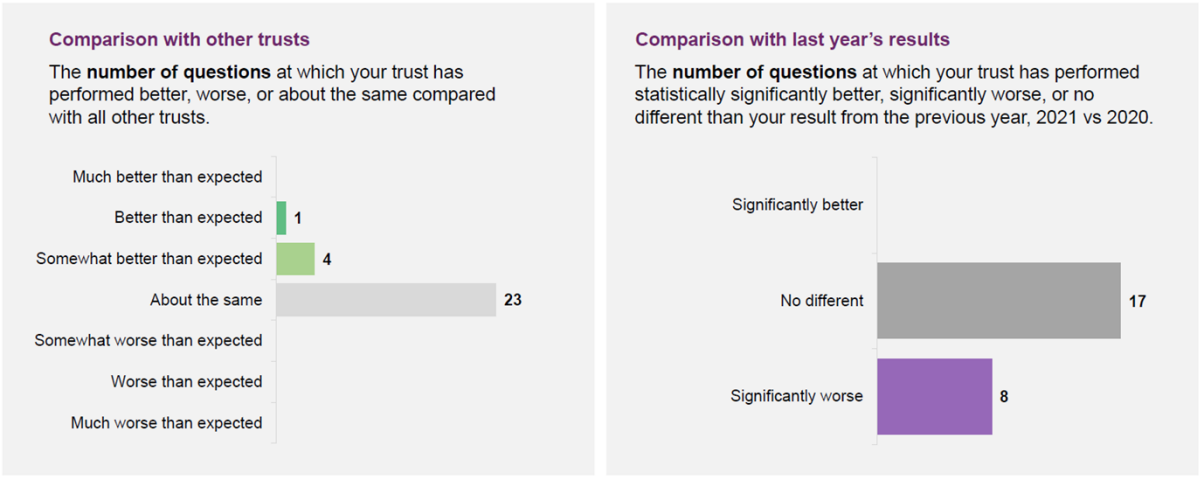


Figure 2. Comparison with other Trusts and against ourselves last year

This is a mixed picture, with the Trust performing better or about the same as other Trusts for all questions (see figure 2 above), this will be discussed in the benchmarking section.

However, the Trust performed significantly worse than itself when compared to the results of last year in 8 questions. The Trust performed about the same on all other questions in comparison with its own position last year.

Figure 3. Top 5 scoring questions and position against national average

Figure 3 above shows that the Trust had the highest score (8.1) for question 19, a question relating to people knowing who to contact out of hours if they had a mental health crisis.

For all of the highest scoring questions, the Trust performed better than the national average.

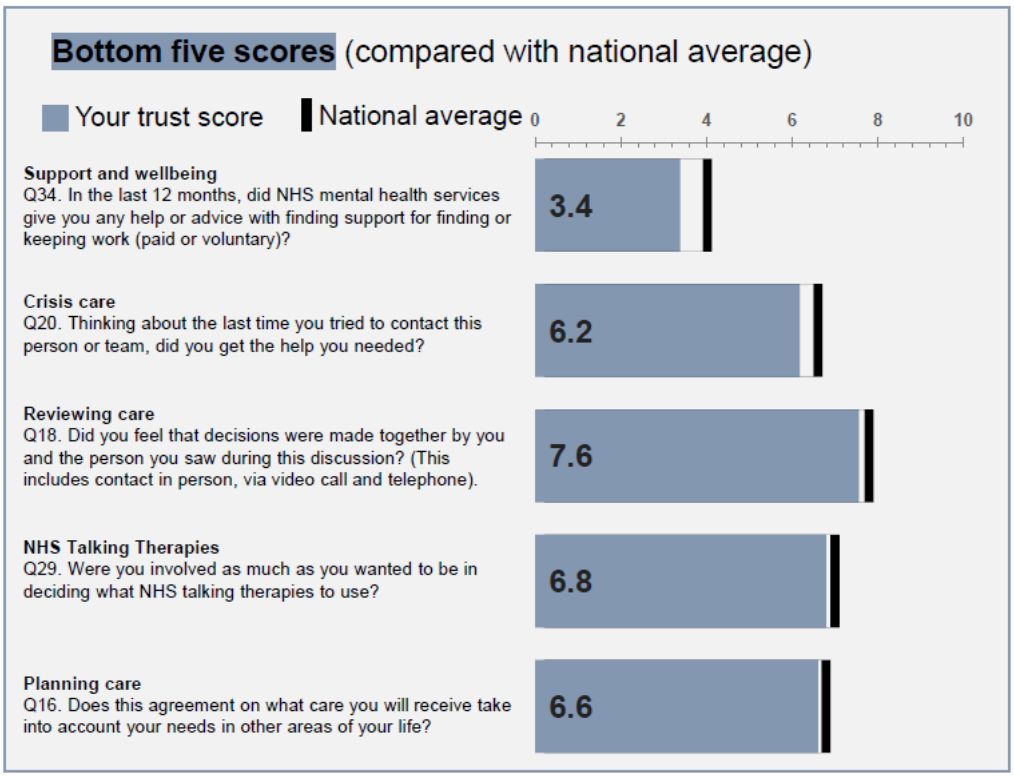


Figure 3. Bottom 5 scoring questions and position against national average

Question 34 was the Trust's worst scoring question and was around advice and support to find or continue with work. The score is 3.4, the national score for this question is 4.

It is worth noting that the Individual Placement Support team, which was set up in late 2019 is a growing resource that supports with the needs set out in question 34. As their provision is growing, they are actively seeking the feedback of people accessing the service to respond and change the service to effectively meet the needs of people.

Question 20 is around getting the help needed when contacting crisis services. The Trust received an average score of 6.2, compared with the national average of 6.8.

In the three other questions that the Trust performed worse in, the average scores were not significantly below the national average.

Benchmarking

The benchmarking section is split into 12 categories that incorporate several questions in each, the scores for these questions are assigned an average score by section and this is represented in comparison with all other Trusts that took part in the survey.

For purposes of being succinct these will be discussed as an overview with examples of the best and worst performing sections in comparison to other Trusts. The full results are available by following the link in the Executive Summary.

For all of the 12 sections the Trust was rated as ‘about the same’ as other Trusts in all of the sections. The Organising Care and Medicines sections offered scores closest to the positive end of the scale (see figure 4 as reference).

Talking Therapies and Support and Wellbeing saw the Trust position closer to negative end of the scale (see figure 5 as reference).

The remaining sections saw the Trust ranked beyond the middle of the scale, towards the positive end of the scale, with a classification of ‘about the same’ as previously discussed.

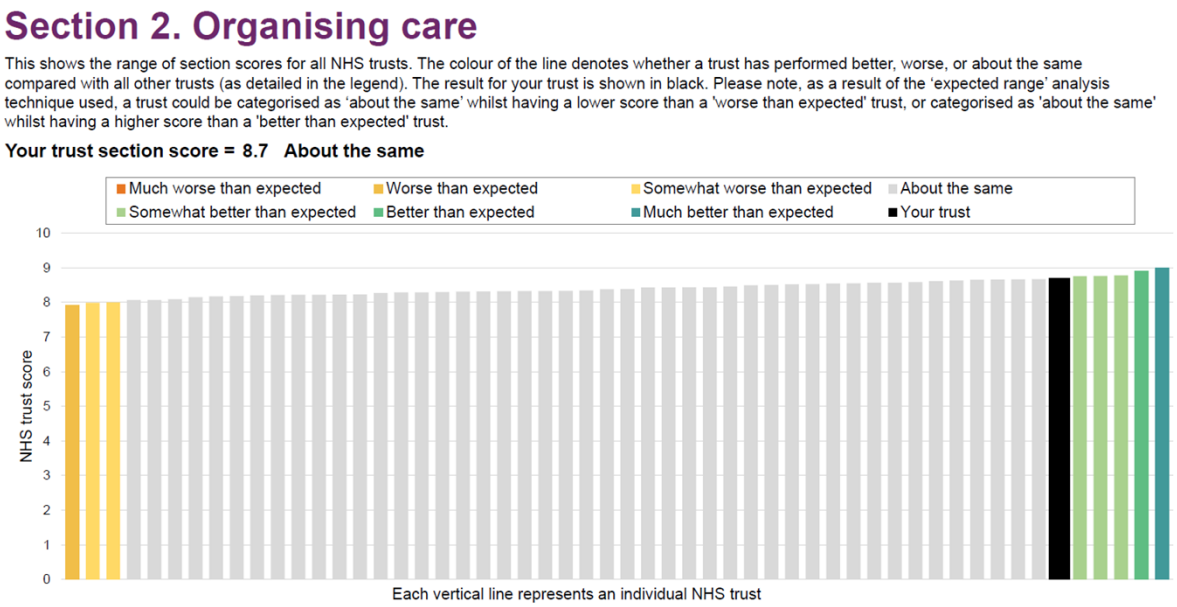


Figure 4. Table showing Trust position in comparison with all other Trusts for Organising Care section

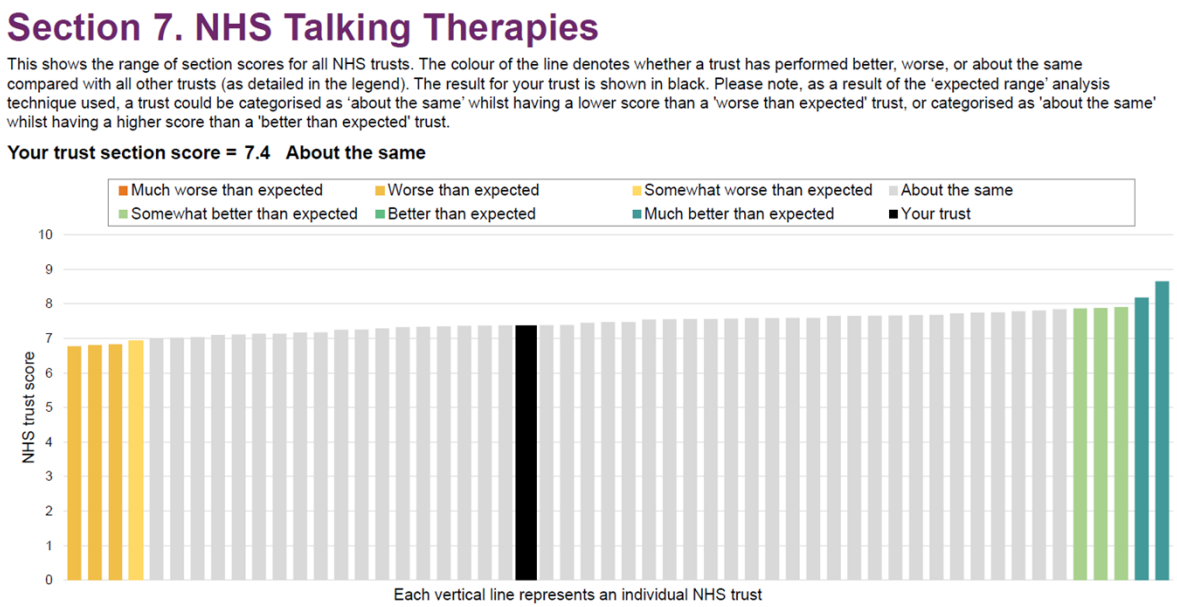


Figure 5. Table showing Trust position in comparison with all other Trusts for Talking Therapies section

Change Over Time

This part is reported in 11 sections, this is because the final section of the benchmarking is not applicable in the change over time section.

The results are set out as a position against the Trust's score last year as a Mean score, as well as against the national average score. See table 1 below for position by section.

Section	Decrease on last year	No Change on last year
Health and Social Care Workers	2	1
Organising Care	1	2
Planning Care	1	2
Reviewing Care	0	2
Crisis Care	0	1
Medicines	0	3
Talking Therapies	1	1
Support and Wellbeing	0	4
Feedback	1	0
Overall views of Care and Services	1	1
Overall	1	0

Table 1. Position by section when compared with last year's score

In comparison with the national average score, there were 25 questions that offered an opportunity to compare the Trust position with the national average.

The Trust was better than the national average in 13 questions, the same as the national average in 10 questions and worse than the national average in 2 questions.

Report to Board
2nd February 2022

Title of report	**Service User and Carer Experience Report (Q3 2021/22)**
Report author(s)	**Paul Sams, Feedback & Outcomes Lead Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning & Quality Assurance**

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

Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	26/01/22	Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality & Safety	
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board		CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

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

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

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

CNTW Service User and Carer Experience Summary Report

Quarter 3 2021-22

Executive Summary

This report discusses feedback received by CNTW from service users/patients and carers through available internal and external options during quarter 3 of 2021-22.

Recommendations

The Board is asked to:

- Note a decrease in uptake of Points of You during the quarter
- Note Service users make up 76% of feedback received through Points of You
- Note the Trust average Friends and Family Test score is 8.56 (up from 8.53 in quarter 2)
- Note the carer voice is less evident this quarter through Points of You
- Note all Healthwatch in CNTW footprint are now sharing feedback when requested

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Service User and Carer Experience Report

Quarter 3 2021-22

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

Ask Section:
This section includes an overview of levels of feedback, including some comparison with the previous quarter.

Points of You
During Quarter 3 of 2021/22 the Trust received 568 Points of You (PoY) surveys. This is a 49% decrease from the previous quarter.

Table 1. PoY uptake by locality

Locality	Total PoY responses
South	236
Central	173
North Cumbria	76
North	70
Others	13

Patient Advice and Liaison Service (PALS)
Table 2. Contacts with PALS from service users and carers by locality
Information collated by North of Tyne PALS.

Care Group	Q2 2021/22	Q3 2021/22
Central Locality	16	21
South Locality	3	4
North Locality	13	3
Non-Service Specific (NTW)	57	32
Total	**88**	**60**

NHS.net
During Quarter 3 the Trust received feedback through this platform on 2 occasions. Both of these were offered a response and options to discuss further. On both occasions the feedback was for a specific team, First Steps in Cumbria and Alnwick Community mental health team. The teams were contacted and offered the

opportunity to respond, on both occasions this opportunity was taken and a personalised response was offered to the specific feedback shared, which was uploaded to the website.

Care Opinion
All feedback visible on the Care Opinion website is feedback received through the NHS.net website, as such, all discussion of this feedback will be done once in the 'Listen' section under the NHS.net heading.

Healthwatch
The Trust now has an agreement with all of the local Healthwatch organisations within its footprint to get quarterly updates on feedback received about services. This developed as it became clear that not all feedback is published on their webpages.

Table 3. Feedback available through individual Healthwatch webpages

Name	Times feedback offered during Quarter 2 2021/22	Times feedback offered during Quarter 3 2021/22
Healthwatch Cumbria	0	0
Healthwatch Gateshead	1	3
Healthwatch Middlesbrough	0	1
Healthwatch Newcastle	3	2
Healthwatch North Tyneside	0	0
Healthwatch Northumberland	0	0
Healthwatch South Tyneside	0	0
Healthwatch Sunderland	0	0

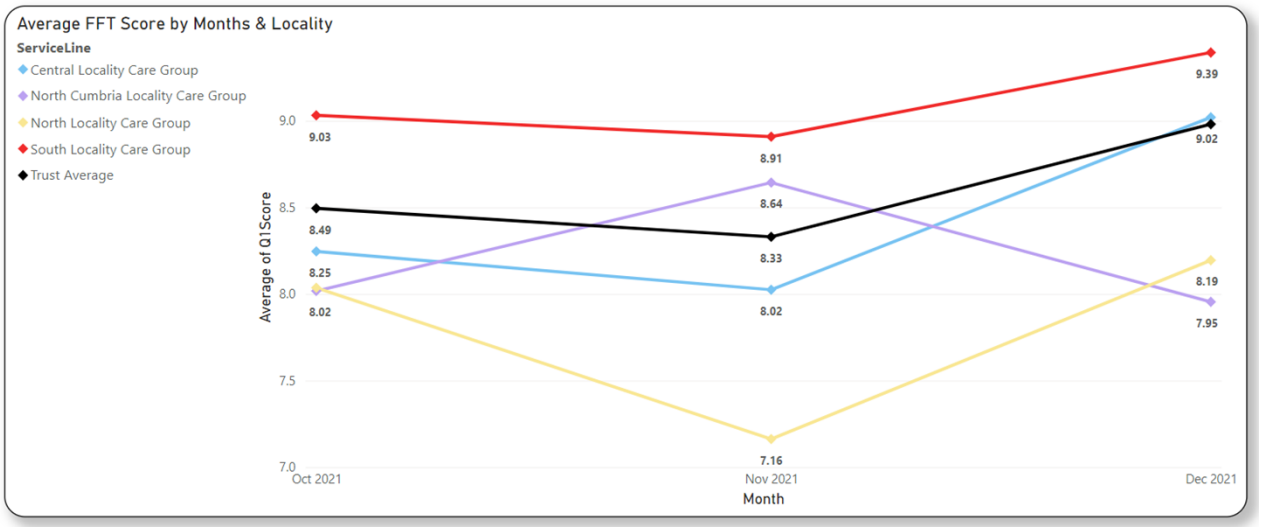
Listen Section:

Points of You
This section will discuss what is being said when people are feeding back their experience of Trust services and what the Friends and Family Test (FFT) score is. Question 1 of PoY is the FFT question 'Overall, how was your experience of our service?'.

Table 4. Average FFT score in current and previous quarter

	Average FFT Score for Quarter (out of 10) Quarter 2 2021/22	**Average FFT Score for Quarter (out of 10) Quarter 3 2021/22**	**Total number of responses Quarter 3 2021/22**
Trustwide	*8.53*	8.56	568
South	*8.90*	9.09	236
Central	*8.65*	8.40	173
North Cumbria	*8.12*	8.30	76
North	*8.28*	7.61	70
Others*	*6.11*	7.69	13

*Include Dietetics and North East Mental Health and Deafness Service feedback, not assigned to a locality.



Graph3. FFT by average score by month and locality

Table 5. PoY Comments received by broad theme

	Positive	Neutral	Negative	Compliment
Trustwide	1620	172	289	24
Central	523	63	103	8
North	197	24	59	2
North Cumbria	202	26	54	1
South	667	59	64	13
Others*	31	0	9	0

*Include Dietetics and North East Mental Health and Deafness Service feedback, not assigned to a locality.

Table 6. Themed comments during quarter 3 2021/22 – see appendix 1 for examples of comments.

Category	Compliment	Positive	Neutral	Negative
Access to Treatment or Drugs		2		2
Admissions and Discharges		1		5
Appointments		22	8	15
Clinical Treatment		4	2	1
Communications	7	459	49	74
Facilities		27	21	13
Other		10	18	2
Patient Care	6	532	48	113
Prescribing		3	4	4
Privacy, Dignity and Wellbeing		10		3
Staff Numbers		2	7	9
Trust Admin/ Policies/Procedures		2		2
Values and Behaviours	11	541	12	31
Waiting Times		5	3	15
Total	**24**	**1620**	**172**	**289**

Table 7. Average FFT score by sexuality

Sexual Orientation	Average FFT Score	Number of Surveys
Queer	0	1
Blank	4.8	14
Pansexual	6.9	4

Questioning	6.9	4
Heterosexual	8.7	270
Not Stated	8.7	232
Bisexual	8.8	18
Other	8.8	10
Asexual	9	5
Lesbian/Gay Woman	9.6	6
Gay/Gay Man	10	4

The lowest possible score of zero was offered by an individual person choosing 'queer' as their sexuality. This individual reflected on a poor experience with the Adult ADHD Service.
'Lesbian/Gay Woman' and 'Gay/Gay Man' feedback offered the Trust the best average FFT scores of 9.6 and 10 respectively.

Table 8. Average FFT score by religion

Religion	**Average FFT Score**	**Number of Surveys**
Blank	5.5	17
Paganism	5.5	5
Other	6.7	12
Atheism	8.2	30
Islam	8.5	5
Not Stated	8.8	250
Hinduism	8.8	2
Jehovah's Witnesses	8.8	2
Christianity	9	235
Buddhism	10	3
Rastafari	10	1
Spiritualism	10	5
Taoism	10	1

The religious group offering most feedback was 'Christianity' and they offered an average score of 9, which is above the Trust average of 8.56. The largest number of completed PoY were from people who did not state a religious group and their average score was 8.8, again this was above the Trust average.

The least satisfied groups were those who left the question blank and people who chose 'Paganism'. These groups accounting for 17 and 5 PoY respectively. Patient Care was the most commonly themed comment from these two groups with 17 comments.

Table 9. Average FFT score by age

Age	**Average FFT Score**	**Number of Surveys**
Prefer not to say	2.8	17
25 to 34	7.9	70
0-18	8.2	15
Not Stated	8.4	20
35 to 44	8.4	83
19 to 24	8.6	35
45 to 54	8.8	79

85+	8.9	26
55 to 64	9	88
65 to 74	9.2	71
75 to 84	9.3	70

People who preferred not to tell the Trust their age when completing a PoY remain our least satisfied group, offering an average score of 2.8 (out of 10) from 17 that were completed. This is much lower than the score this group offered in the previous quarter, when it was 5.6. Patient care was the most common theme for comments from this group.

People under the age of 18 offered a significantly higher satisfaction rating this quarter of 8.3 from 15 PoY, a significant satisfaction increase from 6.6 in quarter 2 of 2021-22. Positive comments offered by this group totalled 36 with only 6 negative comments offered.

Patient Advice and Liaison Service
16 issues relate to Communication, including 8 relating to information about services. 7 issues relate to Care & Treatment, of these 3 were regarding the treatment plan, 1 regarding perceived delay in receiving treatment, and 3 regarding medication/pain relief.

NHS.net and Care Opinion
On two occasions service users chose the NHS.net platform to share their experience of Trust services. On both occasions these related to community based services, Alnwick Community Mental Health Team and First Steps Cumbria. Both experiences were negative and related to perceived quality of care offered. Responses were offered by each team.

Healthwatch
No examples have been published through any Healthwatch websites, but have been shared with the Trust to support learning from experiences of service users and carers.

Do Section:

A number of projects are ongoing to make feedback more accessible for service users, carers, staff and stakeholders. They include:

- Making the feedback process more accessible and inclusive.
- Developing staff awareness of the PoY dashboard and its functionality.
- Developing and maintaining links with Healthwatch to access more Trust related feedback than is published.
- Development of a 'You Said – We Did' poster to make responding to feedback quick and effective for all teams in the Trust.
- Leading on a national collaborative between Trusts, self-advocates, service users and carers, that develops good practice around feedback.

Appendix 1 – Examples of comments to from dominant positive and negative themes

Some examples of positive comments from Values and Behaviours:

‘Because my husband’s team were always friendly and helpful and calm in dealing with some distressing consultations.’ – Neurorehabilitation Outpatient Clinic (Walkergate Park)

‘I found all staff helpful and supportive and that made it a lot easier to engage properly and get the correct results.’ – Individual Placement Support

Some examples of positive comments from Patient Care:

‘To employ more professionals like Sam who has been able to detect symptoms and set a ball rolling so we are able to help my son get back on track and to achieve a better life.’ – Adult ADHD Service

‘She learnt about his needs and behaviours well and provided a comprehensive plan for him.’ – Newcastle Behaviour Support Service

Some examples of positive comments from Communications:

‘Spending time with people, talking about my illness and reflecting on it everyone is so nice including Dr's and nurses.’ – Bluebell Court

‘The assessment team crisis took time and listened to parents concerns and showed excellent compassion.’ – Crisis Resolution and Hone Treatment, Sunderland

Some examples of negative comments from Patient Care:

‘Nothing if you work full time and unable to attend groups.’ – North Tyneside Recovery Partnership

‘Try and keep one to one wherever able, read notes prior to session. Don't go over old ground at every meeting.’ – North Tyneside Community Treatment Team

Some examples of negative comments from Communications:

‘My overall experience of the service is not good. I feel doctors and staff do not listen to concerns or issues regarding heath and appointments, which can sometimes put my health at risk.’ – Newcastle West Community Treatment Team

‘Very limited contact with the team not explained reasons for their decisions.’ – Community Mental Health Assessment and Recovery

An example of negative comment from Values and Behaviours:

‘Gibside rehab ward desperately requires an in reach or ward based psychiatrist, you are failing on meeting basic mental health needs’ – Gibside

Appendix 2 – 'Ways to offer feedback' webpage

Ways to offer feedback

Your honest feedback, good or bad, makes sure our services are the best they can be. Feedback will never change your care in a bad way. It could lead to good changes in the future for the services we offer.

If you have any questions, comments or problems we hope that you will talk to someone who is providing your care. We understand that you might prefer to talk to someone else.

Here are some options for sharing your feedback.

If you require additional support to feedback or want advice on the best option or the experience you want to share, contact POY@cntw.nhs.uk or call 07747 793 572 and we will get back to you.

Talk to us directly using the following:

This is a way of sharing your thoughts on care you received from a service or ward. This could be any type of experience, good or bad. You can ask us to let you know what happened with your feedback.

PALS

Patient Advice and Liaison Service (PALS) provide confidential advice and support to service users, relative or carers when you have a concern or query about care.

Comments and Complaints

When you believe something went wrong, let us know. This will give us the opportunity to make sure you or someone else doesn't have the same experience.

External/independent options are:

Healthwatch

The main purpose of Healthwatch is to understand the needs, experiences and concerns of people

In this section

- Information for referrers
- Press and media
- Patient Advice and Liaison Service
- Comments and complaints
- Freedom of Information
- Translation
- Ways to offer feedback

Get involved

Become a member

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
2nd February 2022

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

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

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	Covid19 Gold Command

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

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

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

Safer Staffing Report – including Six Month Skill Mix Review
Report to the Board of Directors
2nd February 2022 (November Data)

Executive Summary

The purpose of the report is to provide assurance on the current position across all inpatient wards within CNTW, in accordance with the National Quality Board (NQB) Safer Staffing requirements. The following report includes the exception data of all wards against Trust agreed Safer Staffing levels for the period of November 2021. The report includes information on Allied Health Professionals and Medical staffing.

The report provides a summary position from each locality alongside the narrative per ward area. Skill mix review information is also provided by Locality.

Vacancies and maternity leave continued to contribute to challenging staffing levels, with the Carleton Clinic in Cumbria, Children and Young People's Services and St George's Park identified as areas requiring additional support. With respect to the Carleton Clinic, Rowanwood ward was closed at the end of August and remained closed throughout November, to ensure safe staffing levels across all remaining operational services. Covid-19 outbreaks and related absence were identified in North Cumbria and North Localities in November.

As detailed in the previous report, due to exceptional pressure, compounded by vacancies and Covid and non-Covid related absence, the Trust's Staffing Contingency Policy and Procedure were invoked in July 2021 and continued in place throughout November.

Weekly Director-led Ensuring Operational Delivery meetings were introduced in October, in addition to daily huddles, and continued throughout November. These meetings focused exclusively on Safer Staffing levels and prioritised movement of staff as needed across sites and services. The staffing related activity during November is summarised as:

- Ward Managers, Specialist Nurses and Nurse consultants were included in the staffing establishments.
- Corporate clinically registered staff members continued to be redeployed into clinical areas to support safe staffing levels during November.
- Staff vaccination clinics continued to be in place throughout November to provide Covid-19 booster vaccinations and influenza vaccinations. Temporary and corporate staff members also supported these clinics, with a view to reducing the impact on direct clinical services.
- The Staffing Solutions team continued to work to maximise the capacity of bank and agency resource to address temporary staffing needs. The availability of temporary staff was also affected by Covid-related sickness and isolation requirements.
- New Nursing Registrants (preceptees) continued to be supported by experienced registered nurses (preceptors) in areas with the highest acuity and challenging staffing position.
- The 'Keeping in Touch' process was introduced across the Trust, which involves at least weekly contact with newly appointed staff member by the relevant manager to ensure that the staff member is supported appropriately into their induction and team in due course.

To support strategic staffing developments, the Recruitment and Retention Task Force has prioritised activities falling from the Executive Director specific workstreams:

- Recruitment: Rajesh Nadkarni
- Retention: Ramona Duguid
- New Roles: Gary O'Hare

- Terms and Conditions: Lynne Shaw

Specific recruitment activity in November included:

- a Trust-wide band 5 advert, with a locality focus
- preparation for band 3 recruitment, as part of the Trust's engagement in the NHS England and NHS Improvement (NHSE & NHSI) Health Care Support Worker Zero Vacancy Project, with support from Indeed, commissioned by NHSE & NHSI.
- A bid was submitted to NHSE & NHSI for funding to support an additional twenty-five Internationally Recruited nurses, which was successful.

Recommendation/summary

To receive the executive summary and locality data attached noting information and assurance to manage current staffing pressures

Purpose of this report

This report is an exception report that highlights wards that are either 10% + under or 20% + over planned staffing levels.

The exception reporting is via a RAG rating that identifies the following categories:

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

North Cumbria Locality

North Cumbria CBU has 12 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Ashby	126.96%	170.57%	117.49%	169.28%	High usage of non-registered staff due to long term segregation and increased observation levels. Staff on day and night shift increased to reflect high acuity levels, increase in self-harm, assaults towards staff, damage to property and targeting of staff requiring movement between day and night shift. Continuation of long-term segregation to maintain patients and others safety. 2 x registered staff going through HR process. 1 x registered nurse on long term sick leave. 1 x registered nurse on maternity leave. Over on non-reg due to continued arrangement via NHSE financing x4 agency staff to support patient admitted following court order.
Lennox	83.71%	221.41%	104.94%	427.56%	High usage of non-registered staff due to high levels of observation and increased staffing pressure due to sickness absence, staff undergoing disciplinary investigation and vacancies Current staff vacancies 3 x Band 6 vacancies. 7 x Band 3 vacancies – 3 appointed but still awaiting start date. X1 Band 7 on maternity X1 Band 3 on maternity
Redburn	147.19%	112.35%	103.45%	144.63%	As part of the new CEDAR / integrated services at Ferndene, Redburn and Fraser have merged and became one ward staff team on 8th November. This had a positive impact on November's staffing levels. 2x Band 6 LTA 2 x Band 6 STA 2 x band 5 STA 2 X Band 3 LTA Intermittent staff sickness due to general sickness and covid related. Maternity 1 x Band 5 Continued increased acuity with complex patients requiring increased observations, seclusion and Long-Term Segregation.

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Stephenson	77.00%	108.45%	50.83%	114.11%	**NOW RIDING WARD** As part of the new CEDAR / integrated services at Ferndene, Stephenson and PICU have merged and became one ward / staff team on 8th November. Following the merge there became high levels of Registered Nurse sickness absence. Riding safer staffing on night duty is two Registered Nurses, however, they worked with only one in November. LTA: Band 6 – x6; Band 5 – x1; Band 3 – x3 Maternity: Band 5 – x1; Band 4 – x1; Band 3 – x1 Continued increased acuity with complex patients requiring increased observations and Long-Term segregation.
Edenwood	193.09%	259.26%	187.56%	284.37%	Edenwood have managed a split nursing team to support a patient who required nursing within the seclusion suite on Rowanwood. The nursing team consisted of 4 x staff for days and nights to ensure a safe seclusion entry. High level observations for remaining patients on Edenwood requiring 4 x staff for days and nights to ensure safer staffing levels. Vacancies include 2x band 6 staff In addition there are 5x preceptor nurses who require oversight from registered nurse. Absence 11%
Hadrian	84.07%	210.08%	111.81%	214.75%	High numbers of vacancies on Hadrian: 1x Band 7; 2x Band 6; 6x Band 5; 10 Band 3 Unfortunately, an outbreak led to an increase in short term absence, in addition to non-covid absence prompting an increase in the requirement for band and agency. Absence increased to 13% There has in addition been high levels of violence and aggression and which have prompted an increase in high levels of observations.
Oakwood	66.98%	192.89%	113.59%	159.73%	During the month of November safer staffing model was maintained at 5/4/4 per day. Staffing levels were increased over allocated days responsive to clinical need to support appointments which were at times timely i.e – DAT scans Management team were readily accessible to provide responsive support and supported as 2nd qualified Episodic short-term sickness recorded x2 HCA- Long term sickness x1 RMN long term sick x1 well-being practitioner – Long term sickness x3 COVID related absences (short term) – due to presenting type symptoms pending PCR results all of which were negative x2 Special leave requirements (x2 days in duration for each) x1 OT commenced home working plan due to pregnancy (28 weeks)

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
					x4 Reasonable adjustment plans in place to support return to work needs and pregnancy x2 HCA restricted clinical duties x1 Clinical Lead – restricted patient contact Wider site support also planned for daily, facilitated on daily staffing calls, additionally Bank and Agency utilised Increase in clinical acuity necessitating for x1 Increased Level 3 Observations x2 Level 3 Observations required in accordance to Nutritional Choking Risks – care planned need x4 Patients presenting with significant Nursing needs, requiring skilled and timely intervention, therefore staffing was increased to reflect, subject to daily review Absence increased to 11%
Ruskin	187.91%	134.67%	174.25%	163.49%	Safer staffing levels increased for Ruskin due to high number of patients on enhanced observation levels. 1x RMN – LTS 2x HCA's - LTS 1x Well being practitioner - LTS 3x HCA's not working clinically Absence data currently at 13%
Yewdale	71.32%	142.22%	76.23%	296.28%	Short notice absence resulting in an inability to cover at such short notice. Some challenges covering with agency and bank. Slight an increase of COVID related absences with isolation periods aside from non covid absence. Absence currently at 10% improvement from last month. 1x Band 3 Long Covid Pressures to release staff to complete PMVA to enhance safety on ward. 2x short term contracts with Ranstad Following vacancies for Yewdale: 2.8 x Band 5; 1 x band 5 OT
Lotus	77.13%	74.40%	102.71%	90.12%	Lotus is a standalone unit in Middlesbrough. Safer staffing is a minimum of two Registered Nurse 24hr / 7 days. Night duty is priority to have two Registered Nurses due to limited access to other members of the leadership team and MDT. 1 x B4 LTS; 2 x B6 LTS; 4 x B3 LTS Lotus have Registered Nurse and Band 3 vacancies Intermittent staff sickness due to general sickness and covid related Increased clinical acuity, increased observations, and seclusion.

North Cumbria

Inpatient CBU

Inpatient services continue to experience challenges when meeting safe staffing figures for both registered and non-registered staff.

High levels of acuity particularly across acute services. Continuous staffing pressures resulting in high levels of bank and agency use. On a positive we are able to source qualified agency cover however this isn't always qualified staff who are familiar to the patient group and wards.

A patient from Edenwood has required nursing within seclusion suite within Rowanwood (temporarily closed ward) due to escalation in risk. This has required a dedicated team to support on a 4:1 basis including a registered nurse which has impacted on safer staffing requirements significantly.

Unfortunately, an outbreak led to an increase in short term absence, in addition to non-covid absence prompting an increase in the requirement for band and agency.

Nurse consultants, Clinical Managers specialist nurses and ward managers are providing cover to wards.

We have a daily staffing/sitrep meeting attended by ward managers, CMs, AND and AD to monitor staffing across site and gain a greater understanding of projected needs for the week.

We continue to have high levels of vacancies, coupled with staff both registered and non-registered being appointed into other roles across the trust. Fixed term contracts have been offered to our agency colleagues to provide consistency to the wards. Accepted by two regular agency staff on Yewdale. We continue to seek opportunities to recruit to our services.

There remains a significant challenge with recruitment into North Cumbria Inpatients with many vacancies, both qualified and unqualified, remaining unfilled due to the location. Rolling recruitment campaigns continue for both registered and non-registered staff across all inpatient areas. We have commenced work with NHS I and Indeed Recruitment to scaffold recruitment campaigns to make process more lean and have successful appointed 8x band 3 nursing assistants following a recent recruitment drive. All 8 have been aligned to our inpatient services scaffold staffing pressures.

Specialist CYPS CBU

All wards have had high levels of clinical activity over this period including increased observations, seclusion, and long-term segregation. This has required an increase in staff to support patient safety which is reflected has taken the safer staffing levels over normal level.

There is continued significant pressures in covering register nurse shifts. This is due to registered nurse vacancies, sickness and COVID -19 staff absence. CYPS have a rolling advert out to recruit into these posts, however, we continue to see a rising number of staff leaving the service to take up career progression opportunities within community services within and outside the organisation.

To support staffing numbers, there was a further campaign for band 3 nursing assistants in November. Several successful candidates were recruited and are awaiting HR clearance before start dates can be arranged.

Clinical Managers, Ward Managers and Associate Directors meet each morning, Monday to Friday, to discuss staffing levels across all three sites. During this meeting staff numbers, level loading and skill mix are reviewed and mutual aid arranged where possible.

There continues to be staff absent from clinical duties pending disciplinary investigation outcome and staff who have been temporarily moved to non-clinical duties pending a fact find. There are a number of staff across inpatient wards on the apprenticeship programme which further impacts the whole time equivalent on each ward. Ward Managers are working in the safer staffing numbers to support registered nurse cover and provide visible clinical leadership and to support and monitor staff resilience and wellbeing.

North Cumbria Locality Multidisciplinary Team Staffing Summary

	Staff in post	Vacancies
Physiotherapists	2.8	1
Occupational Therapists	13	2.3
Psychologists	4	1
Dietitians	4.5	1.8
Speech and Language Therapists	2.6	2.2

Recruitment & Retention:
Inpatient CBU: There remains a significant challenge with recruitment into North Cumbria Inpatients with many vacancies, both qualified and unqualified, remaining unfilled due to the location. Rolling recruitment campaigns continue for both registered and non-registered staff across all inpatient areas.

We have commenced a piece of work with NHS I and Indeed Recruitment to scaffold recruitment campaigns to make process more lean and have successful appointed 8x band 3 nursing assistants following a recent recruitment drive. All 8 have been aligned to our inpatient services scaffold staffing pressures.

Specialist CYPS CBU: Rolling recruitment campaigns continue for both registered and non-registered staff across all three inpatient areas.

Lotus ward continues to operate on a reduced bed capacity due to outstanding vacancies and recruitment challenges.

Ferndene and Alnwood - 22 Band 3 nursing assistants were successful in the August and November interviews, some now have start dates however we are still waiting for checks and clearances on most of them to come through before we can arrange start dates.

The CBU held registered nurse interviews for both Band 5 and Band 6 vacancies in November. There were few applications for the Band 5 vacancies and only 2 candidates attended for interview. There was further disappointment when following offers being made to both candidates they declined after being successful in other interviews. All Band 6 applicants withdrew prior to interview.

There continues to be an ongoing challenge within Children and Young Peoples Specialist Services with Band 5 Registered Nurse vacancies which are increasing due to existing staff seeking opportunities for progression elsewhere.

Developments:
On 8th November 2021 The Riding ward opened as part of phase one of the CEDAR project at Ferndene. This development saw PICU and Stephenson wards merge to become one ward providing care and treatment for young people on both the mental health and learning disability pathways. The Riding ward is comprised of 4 mental health beds, 3 learning disability beds and 3 low secure beds.

This development saw the staff teams from Stephenson and PICU became one team. It represents an excellent opportunity for staff to expand their skillset by shaping how the care and treatment of young people across both mental health and learning disability pathways is provided in the same ward environment.

North Locality

The North CBU has 10 inpatient wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Alnmouth	77.43%	227.52%	66.09%	252.34%	Registered Nurse vacancies and Registered nurse sickness and absence has contributed to reduction in safer staffing levels. Registered Nurse gaps filled by support across site at daily staffing meeting (Carter Meeting / Staffing Huddle) Unregistered Nurse numbers are over, due to backfilling Registered Nurse gaps.
Bluebell Court	135.86%	81.16%	101.91%	77.61%	Registered: Bluebell safer staffing has increased to 2 registered staff on days following increase in beds Unregistered: increased staff absence due to maternity and sickness
Embleton	88.58%	136.74%	123.71%	190.99%	Registered Nurse vacancies are documented and the ward has welcomed two Preceptors to the ward team. Registered Nurse gaps at night are supported by night pool Registered Nurse – there is no means of this information pulling through on the TAER system. Additional Registered nurses required for direct care needs.
Hauxley	110.14%	91.55%	119.35%	106.04%	Unregistered nurses during day lower due to long term sickness and vacancies.
Kinnersley	94.68%	183.73%	161.16%	119.26%	Registered: registered day staff protocolled to support shortages on site. Increase in registered night staff due to clinical activity/service need Unregistered: increase due to individualised care packages
Newton	79.41%	178.91%	104.92%	208.54%	Registered: under percentage due to staff vacancies and part time staff contract. Staff have left to move on to other roles leaving vacancies. Unregistered: increased due to individual care packages and increased observations.
Warkworth	84.29%	204.11%	86.39%	172.59%	Significant Registered Nurse vacancies and long term sickness including covid absence and isolation. High level of acuity around enhanced engagement and observation and seclusion on and off site. Unregistered Nurse numbers increased to support Registered Nurse gaps. Night pool Registered Nurse supporting some nights which does not show on TAER.
Woodhorn	69.73%	156.57%	100.08%	114.46%	Registered nurse during the day below safer staffing numbers due to current vacancy levels and long term sickness. Registered nurses supported Woodhorn from other clinic areas to ensure safer staffing levels met. Unregistered nurses on day shift was significantly higher than safer staffing levels due to the level of observations, which were escalating one to two person eyesight or intermittent

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
					observation escalating to one to one. There has also staff supporting observations within the acute setting.
Mitford	107.66%	121.34%	89.63%	106.95%	Some registered nurse vacancies have been filled by international recruitment and awaiting pre-employment checks. There is still a number of registered and unregistered vacancies requiring the use of bank, overtime and agency to ensure staffing numbers remain safe. Additional staffing has also been required to backfill recruited staff until PMVA training has been complete and covid related absence.
Mitford Bungalows	86.50%	107.71%	109.11%	110.39%	Ongoing use of bank and overtime to support registered and unregistered vacancies. Some registered nurse vacancies have been filled by international recruitment, others remain vacant. Unregistered staff employed, awaiting pre-employment checks to support fill rate, additional outstanding clear vacancies. Agency not being utilised for support to date.

North Locality

All inpatient areas continue to experience high levels of activity throughout November 2021. The two Inpatient CBUs continue to experience high levels of non-Covid-19 related absence The Inpatient CBU total absence percentage has reduced from 9.34% to 8.50% within month and the Learning Disability and Autism CBU has reduced from 10.71%. to 8.62% The overall absence for both of the inpatient CBU's for is 8.55%.

Each ward continues to experience significant staffing pressures particularly when ensuring sufficient Registered Nurse cover to meet the safer staffing requirements. There continue to have been shifts where wards have been working with one qualified nurse per shift due to short notice and long term absence. Out of Hours it is also noted that this has impacted on Night Coordinators and the Point of Contact on call.

Gaps in numbers are addressed by moving staff around sites to facilitate both patient and staff needs and forecasting the week ahead in an attempt to maintain safer staffing levels; The use of Carter meetings /Staffing Huddles supports this risk assessed approach. Ward Managers and Nurse Specialists are routinely been counted within the Registered Nurse numbers to maximise Registered Nurse numbers across all shift patterns, this is not reflected within the safer staffing numbers above as TAER does not provide this function. The numbers within the Unregistered Staff lines reflect the need to backfill Registered Nurse numbers therefore appear significantly higher than established numbers per shift. With regards to skill mix review, the base line Registered Nurse percentage and unregistered nurse percentage has been reviewed to ensure this is appropriate for care provision.

High levels of need and acuity across all pathways continued throughout November 2021 and additional staff resource to implement safe engagement and observation plans, transfers to acute hospital and facilitation of Section 17 Leave has been essential. There is ongoing pressure within the Older Peoples and Acute Pathways with high bed occupancy and significant numbers of enhanced engagement and observations relating to safeguarding and frailty issues.

North Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	Vacancies
Physiotherapists	3.6	0
Occupational Therapists	16.8	1
Psychologists	14	1
Dietitians	2.0	0.0
Speech and Language Therapists	2.7	0.6

Recruitment & Retention:
Recruitment campaigns are ongoing via Value Based Recruitment, with representation on the Trust Value-Based Recruitment Meetings. All vacant posts are proactively being recruited into with interviews taking place for all bands of nursing staff. Adverts are live for all Registered Nurses and Unregistered Nurse posts with planned interview dates. Registered Nurse vacancies within both in-patient CBUs currently equate to 39 whole time equivalents. The majority of these are within the in-patient wards at St George's Park. The vacancy factor within the Autism inpatient wards is mainly Unregistered Nurses and reflect increased care packages. There are an additional 12 Registered Nurses waiting to start within the organisation – these are preceptorship and international nurses and are not due to commence until March / April 2022.

Developments:
Both Inpatient North and Autism and Learning Disability CBU's are working on strengthening flexi-pool resources to enable staff to be more easily deployed in the event of increased acuity and absence. Also combining what are currently separate day and night pools allows for review of skill mix (to increase the Registered Nurse establishment) and improve staff wellbeing and support mechanisms for this important and flexible staff group. The Unregistered Nurse vacancies remain challenging to fill, the locality has positively engaged with the NHSE & NHSI Zero healthcare support worker initiative and expect to start the first round of recruitment in November 2021.

Central Locality

Central Locality has 18 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Aidan	95.32%	102.87%	98.01%	115.17%	Increased clinical activity required additional staffing over night shift.
Akenside	91.19%	114.17%	104.65%	101.98%	Intermittent sickness and increased levels of engagement and observations at times however no major evident pressures throughout November.
Bede	50.68%	484.00%	83.10%	451.99%	Qualified nurse's x 2 LTS absence. 1 Band 5 Vacancy. 1 Band 6 Vacancy. High levels of observations and seclusion use. 1 LTS requires extra staffing use for high level of observation due to complex care plan- x 3 staff per obs care plan.
Castleside	95.07%	165.40%	105.18%	237.65%	Band 3 vacancies and increased Band 3 absence. Increased level of observations.
Cuthbert	94.07%	190.23%	114.65%	202.73%	The figures include Cuthbert Annex which is staffed daily by 1 band 3. High clinical activity has also impacted on the use of nursing assistants.
Elm House	98.49%	108.91%	96.44%	106.32%	Intermittent sickness and increased levels of engagement and observations at times however no major evident pressures throughout November.
Fellside	77.60%	326.40%	91.40%	263.57%	1 x Band 7 vacancy. 1 x Band 6 Maternity leave. 2 x Band 6 LTS. X 2 Band 3 Vacancy. Increase in Qualified nurse sickness absence Sickness absence in relation to isolation requirements- requiring backfill. Increased levels of observation due to high acuity level.
Lamesley	75.60%	337.19%	114.62%	329.47%	Qualified Vacancies. 1 x B5 long term absence Intermittent qualified absence 1 x Band 5 working from home. 2 x B3 long term absence. Increased absence due to isolation requirements. Intermittent B3 absence Increased acuity with complex patient requiring bespoke care package and increased staffing x 2 person observations. High observation levels

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Lowry	93.92%	365.35%	106.53%	332.36%	Increased absence and observation levels due to covid-19 outbreak requiring higher staff resources. Increased acuity and increased engagement and observations.
Oswin	98.96%	78.19%	102.58%	102.59%	During the review period Oswin had a number of empty beds, meaning sickness was not always required to be backfilled.
Willow View	99.76%	139.28%	102.96%	155.66%	Increased observation levels Increased levels of acuity. Band 3 sickness absence ++ requiring backfill via agency and bank usage.
KDU Cheviot	77.24%	141.04%	110.98%	168.84%	Qualified staff vacancy – rolling recruitment for band 5 staff. Short term qualified staff absence. Additional unqualified staff required to meet individual needs of complex patients. 1 patient requires 3:1 engagement / observation at certain times of day to support activity participation. 1 patient requires additional unqualified staff escort outside of KDU perimeter.
KDU Hadrian	55.72%	151.33%	96.85%	101.30%	Band 5 vacancies have been covered with regular and experiences nursing assistants.
KDU Lindisfarne	86.07%	145.88%	104.77%	218.75%	Long term absence of CTL. Short-term qualified staff absence. Ongoing recruitment for band 5 vacancy. Currently 1 patient in prolonged seclusion requiring staff for engagement and observation and to support access to activities outside of the seclusion suite. Additional unqualified staff required to support delivery of activities and ensure appropriate engagement and observation.
KDU Wansbeck	79.20%	193.13%	118.21%	120.03%	Ongoing recruitment for qualified staff vacancy. Short term absence of qualified staff. Additional unqualified staff in place to support therapeutic activities for patients due to absence of qualified staff. Enhanced unqualified staffing required to support therapeutic engagement / observation and support for patients with complex needs.
Tweed Unit	100.40%	225.85%	107.69%	315.23%	Qualified staff vacancy. Tweed has supported other wards with qualified staff. Band 4 employed on ward. Clinically 1 patient in prolonged seclusion requiring staff to support engagement /observation but also to support time outside of the seclusion suite.

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
					1 patient in long-term segregation. Unqualified staff required to support engagement and observation and also to support access to community activities. Due to physical environment of building unqualified staff required to support engagement / observation and participation in activities.
Tyne Unit – LD	68.53%	387.87%	107.62%	443.13%	Qualified – band 5 vacancy – rolling recruitment in place. Band 4 employed on the ward. Short-term qualified staff absence. Adult nurse and 2 registered LD nurses work part-time, one nurse now supporting GP surgery. Additional unqualified staff support required for patients with physical health needs. 1 patient remains in long-term segregation requiring additional unqualified staff support to access community activities / facilities.
Tyne Unit – MH	127.04%	56.64%	103.29%	59.71%	The Unqualified figures are still impacted by safer staffing figures that incorrectly incorporate Tyne LD.

Central Locality

Inpatient Central CBU

All Central inpatient wards continue to experience significant staffing pressures in particular covering qualified shifts to the safer staffing requirements. Wards continue regularly, and as reported via Sitrep, to operate on x1 qualified nurse. Absence up from 9.07% in October to 15.13% in November, with all wards seeing an increase in absence. Absence is due to Covid related sickness, isolation and wellbeing, largely due to the impact of working in such pressured environments, with staffing shortages, working as lone qualified and being protocolled to other wards.

Our Workforce team are ensuring that support is being provided for managers in relation to managing absence of respective team members ensuring that return to work is timely and where necessary supported by PAMS advice and guidance Enhanced wellbeing and staff support measures were also put in place by the Locality.

Some activities continue to be stood down, allowing staff to focus on direct clinical care.

We have seen an increase in the use of seclusion from other CBU's due to the pressure in other localities, causing extra pressure on our wards whilst we look to support those patients.

We continue to carry a number of vacancies across the CBU despite attempts to recruit, most recent band 6 recruitment advert receiving no applicants. The adverts have been repeated. Recruitment is ongoing with the organisation moving to Central Recruitment at this level

Safer staffing levels are reviewed at least daily across the wards including skill and gender mix, activity and forecasting the week ahead to try and maintain safer staffing levels. All wards have experienced increased periods of acuity and engagement and observations inclusive of covid-19 outbreaks requiring extra staffing resources.

Following daily huddles within each CBU, the Inpatient and Secure work closely together to support the wider huddle process via the Trust wide huddle. This enables a thorough review of staffing across the Trust, increasing awareness of pressures and increasing the potential of mutual support.

The role of Night Coordinators working out of hours and supporting wards has supported safer staffing levels during this time.

Secure Care CBU

The Central Locality Secure Services have continued to experience pressures relating to COVID specifically in relation to relatable COVID absences and also other reasons. The secure teams have provided mutual support to Mitford when unpredictable absence has been identified.

In relation to staff absence, data suggests that there had been an increase in absence rates (October 6.50 %) and November slight increase to 6.80%. Measures are in place to support staff absent from the work place such as collective approaches involving Managers and HR colleagues.

During the November period two wards aligned with the CBU experienced COVID Outbreaks (Aidan and Cuthbert wards). Each of the Outbreaks were managed effectively by each of the teams and throughout the different stages of the Outbreak each of the teams experienced staffing challenges, managers were able to ensure their wards remained effectively staffed.

Learning from the outbreaks has been transferable to support outbreak management across the wider CBU and Locality.

Central Locality Multi-Disciplinary Team Staffing Summary

Physiotherapists	1 x Physio on maternity Temp position advertised- no applicants.	1 vacant post
Occupational Therapists	10 x occupational therapists (1 phased return currently) 4 x occupational therapy assistant practitioners 1 x occupational therapy assistant	1 vacancy
Psychologists	6.8wte	2.0wte
Dietitians	3.3	0.0
Speech and Language Therapists	5.5	3.0

Recruitment & Retention:
We continue to carry a number of vacancies across the locality and continue to maximise recruitment opportunities where possible

Three members of staff joined the acute and rehabilitation inpatient team in November:

- Band 5 Assistant Psychologist
- Band 8a Clinical Psychologist in Rehabilitation and Neuropsychology.
- 8b Clinical Psychologist commenced in inpatient services.

We have an 8a post for Older Adult inpatient services coming into post in December.

A fixed term Band 5 Assistant Psychology post is being advertised with a contract until the end of March 2022

Developments:
Recruitment under way within existing workforce of a small number of fixed term Associate Nurse Director positions within the Locality. This will help to strengthen the Secure and Inpatient CBU leadership teams, provide development opportunities for our staff and support the Trust's recruitment and retention strategy.

We are also looking to strengthen our outward facing function, recruiting a locality wide Associate Nurse Director on a fixed term contract.

These posts are to be formally evaluated, both in terms of feedback to staff and also service development and sustainability of leadership.

South Locality

The South Locality has 20 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Aldervale	85.47%	256.39%	115.97%	216.12%	Vacancies: 3 Band 5 Staff Nurse; 6 Band 3 Nursing Assistant Long Term Absence: 1 Band 5 Staff Nurse; 4 Band 3 Nursing Assistant Staffing usage over for unregistered nursing staff due to service users with complex needs requiring additional support with observations Additional unregistered staff required to support transfers to Acute Trust due to level of physical need Filled bank shifts: November 91 Filled agency shifts: November 68
Beadnell	99.18%	94.37%	104.77%	144.39%	Increased in number of Night unreg due to use of B4 Nursery Nurses working twilights to support mothers and babies
Beckfield	126.66%	247.79%	99.90%	230.83%	Vacancies: 6 Band 5 Staff Nurse; 1 Band 4 Assistant Practitioner; 13 Band 3 Nursing Assistant Long Term Absence: 1 Band 5 Staff Nurse maternity leave Over due to increased engagement and observation levels. All shifts have been working above safer staffing numbers due to level of acuity. Continue to support 4 patients out of pathway waiting for step down and MSU beds Filled bank shifts: November 157 Filled agency shifts: November 262
Bridgewell	89.66%	190.18%	109.55%	183.66%	Vacancies: 4 Band 5 Staff Nurse; 1 Band 4 Assistant Practitioner vacancy; 4 Band 3 Nursing Assistant Long Term Absence: 2 Band 5 Staff; 1 Band 3 Nursing Assistant maternity leave One patient on increased observation and engagement levels without additional care packages Large acuity at meal times due to SALT risks – four additional patients requires support with increased engagement and observation levels Filled bank shifts: November 126 Filled agency shifts: November 1
Brooke House	112.48%	73.53%	131.98%	187.60%	Vacancies: 1 Band 5 Staff Nurse Long Term Absence: 1 Band 5 Staff Nurse maternity leave; 1 Band 4 working into Physical Health Team Filled bank shifts: November 91

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
					Filled agency shifts: November 2
Cleadon	94.66%	141.49%	102.00%	187.84%	Vacancies: 3 Band 5 Staff Nurse; 2 Band 3 Nursing Assistant Long Term Absence: 1 Band 5 Staff Nurse; 1 Band 3 Peer Support Worker; 1 Band 4 Nursing Assistant Increased temporary staff use has been observed due to an increase in engagement and observation levels Staff absence has resulted in increased use of temporary workforce particularly as shifts are required to be covered with short notice Filled bank shifts: November 23 Filled agency shifts: November 36
Clearbrook	88.03%	275.96%	105.89%	248.14%	Vacancies: 2 Band 5 Staff Nurse; 2 Band 3 Nursing Assistant Long Term Absence: 1 Band 6 Clinical; 1 Band 5 Staff Nurse Increased use of temporary workforce due to increased engagement and observations levels required to support acuity of need on the ward. In addition there has been absences in relation to COVID isolation which has also impacted on staffing figures Band 5 vacancy impacting on the clinical activity on the ward with increased use of qualified bank staff and the Clinical Nurse Lead working into the numbers to support staffing. Staff Nurse redeployed to Brooke House this is being backfilled with Band 5/3 bank. Filled bank shifts: November 104 Filled agency shifts: November 121
Longview	91.13%	336.15%	126.46%	223.10%	Vacancies: 2 Band 5 Staff Nurse; 3 Band 3 Nursing Assistant; 1 Band 3 Activity Worker vacancy Long Term Absence: 3 Band 3 Nursing Assistants; 1 Band 5 Staff Nurse working from home due to commence maternity Longview is over on staffing due to high clinical activity/ increased engagement and observations levels. In addition DToC patients that require intensive treatment are supported with additional staff resource. Filled bank shifts: November 74 Filled agency shifts: November 126
Marsden	0.00%	0.00%	0.00%	0.00%	
Mowbray	88.01%	183.73%	100.53%	281.25%	Vacancies: 3 Band 5 Staff Nurse; 1 Band 4 Associate Nurse; 3 Band 3 Nursing Assistant; 2 Band 2 Nursing Assistant

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
					Long Term Absence: 1 Band 5 Staff Nurse; 2 Band 3 Nursing Assistants Over for non-registered due to vacancies and increased in bank and agency use due to high number of patients with complex needs on high levels of observation and engagement increase in sickness due to long term absences and several staff positive or isolating due to COVID throughout the month Over for night shift for non-registered staff due to increase in bank and agency usage due clinical acuity levels with patients on higher levels of engagement and observation levels due to complex presentations All new patients require isolation and therefore increase in observation levels resulting in increased need for staff on Night shift Under Registered day cover due to high clinical acuity levels with an increase in patients on high observation and engagement levels, sometimes difficult to obtain like for like cover Filled bank shifts: November 123 Filled agency shifts: November 72
Gibside	71.14%	191.33%	102.74%	148.29%	Increased use of B3 to support gaps in B5 due to vacancies. Complexity of physical care needs of patients needed increased B3 staffing to support
Roker	137.99%	195.89%	103.04%	321.44%	Vacancies: 3 Band 3 Nursing Assistant Long Term Absence: 1 Band 5 staff nurse; 1 Band 3 Nursing Assistant Increased bank & agency use has been observed due to an increase in admissions and need for within eyesight observation levels at the point of admission. (Isolation due to COVID) Increased level of acuity & observation levels particularly on a late shift & night duty resulting in increased use of bank staff & agency staff Filled bank shifts: November 95 Filled agency shifts: November 165
Rose Lodge	92.66%	215.94%	202.26%	289.30%	Vacancies: 1 Band 7 Clinical Lead; 3 Band 5 Staff Nurse; 12 Band 3 Nursing Assistant; 1 Band 6 OT Long Term Absence: 1 Band 5 Staff Nurse long term sick; 1 Band 5 Staff Nurse maternity leave; 3 Band 3 Nursing Assistants; 2 Band 3 Nursing Assistants; 3 Band 3 Nursing Apprentices Increased bank and agency which reflects clinical acuity of need on the ward and vacancies further impacting use of agency. Increased level of need of patient group with patients being supported on increased engagement and observation levels.

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
					COVID Isolations continue to impact on staff numbers resulting in an increase in Bank and Agency use Filled bank shifts: November 207 Filled agency shifts: November 112
Shoredrift	76.23%	605.95%	88.11%	513.38%	Vacancies: 3 Band 5 Staff Nurse; 14 Band 3 Nursing Assistant Long Term Absence: 1 Band 5 Staff Nurse on maternity leave Continued high levels of need that requires an increase in engagement and observations levels, which is reflected in an increase in staffing levels required. Formula in place to meet acuity with staff intervention & numbers, & to ensure safety on the ward. Filled bank shifts: November 137 Filled agency shifts: November 371
Springrise	76.27%	516.96%	101.30%	466.56%	Vacancies: 1 Band 7 Clinical Lead; 3 Band 6 Clinical Nurse Lead; 6 Band 5 Staff Nurse; 6 x Band 3 Nursing Assistant Continued high levels of need that requires an increase in engagement & observations levels. This is reflected in an increase in staffing levels required. Formula in place to meet acuity with staff resource to ensure safety on the ward Long term Seclusion (due to out of pathway) that requires additional support with engagement, observation & activity plan Filled bank shifts: November 106 Filled agency shifts: November 327
Walkergate Ward 1	97.14%	76.19%	110.24%	74.47%	Ward under occupancy. 1 x Band 3 LTS, 4 Band 2 and 4x Band 3 vacancies
Walkergate Ward 2	82.05%	95.05%	103.94%	166.20%	2 Band 5 long term sick; Additional unregistered night duty to support increased engagement and observations
Walkergate Ward 3	86.60%	71.34%	110.52%	139.66%	1 x Band 5 vacancy. Ward under occupancy for parts of month and support provided for other wards.
Walkergate Ward 4	63.89%	115.68%	95.92%	213.38%	Additional unregistered night duty to support increased engagement and observations. Band 5 vacancies covered by level loading to ensure 2 reg nurses every shift
Ward 31A	107.94%	53.08%	110.05%	100.25%	Reduced usage of B3 support due to LTS and vacancies. Where shifts not covered by bank, staff utilised form Intensive Day Service and/or ward manager covered

South Locality

Inpatient CBU:
All wards continue to support increased acuity of clinical need which requires additional staff resource to implement safe engagement and observation plans. There is pressure on the Adult Acute and PICU pathway, the adult acute pathways (particularly Male) which operated in November at maximum or above patient occupancy. Additional impact on the Male Adult Acute Wards and PICU is out of pathway patients who require increased support. The acuity and maximum occupancy is reflected in percentage of staff used to support the level of need. All wards have accessed additional staffing through bank and agency to support the outlined vacancies, absence and complexity of need. The quantity of shifts filled by bank and agency for each ward during November is summarised in the ward narrative.

Vacancies across South inpatients exist, in particular registered Band 5 and unregistered Band 3 posts. All vacancies are registered on TRAC, once applications are received the process of shortlisting and interview schedules are arranged timely to support the recruitment process.

A review of workforce created an increase in Band 3 Nursing Assistant posts. This resulted in additional vacancies, these are included in the safer staffing narrative. The uplift was applied predominantly to the adult/PICU pathway and the learning disabilities assessment and treatment unit. It is anticipated with investment in substantive posts we will be able to reduce the use of the temporary workforce.

The staffing hub is daily, this is increased to twice on a Friday (AM and PM) to plan and support any weekend pressures. All ward managers attend the hubs with senior staff support and overview. The staffing hub identifies what the staffing levels are on each ward and reviews areas that have gaps to maintain safer staffing. This can involve registered nurses working on other wards to support and maintain safer staffing. Increasingly, despite attempts to level load some wards have operated with only one registered nurse, for part or all of the duty. This is due to the outlined Band 5 vacancies, increase in absence and leave. The Ward Manager role is not rostered to work in the numbers, this would only be by exception.

Trust wide Enhanced Bed Management is now operational 24hrs this has supported the pressures experienced by the Night Shift Coordinator for bed queries. The Night Shift Coordinators now have increased capacity to support the wards with the acuity of need experienced during the night.

Staff absence showed an increase in November rising to 10.96%. The teams recognise this is above average, the managers work closely with occupational health, staff wellbeing services and workforce to maintain support with colleagues who are absent, and facilitate return to work at the soonest opportunity.

Neuro & Specialist CBU:
All wards continue to be impacted with Covid sickness/IPC precautions. Level loading across Walkergate Park and specialist wards facilitated through morning huddles and all wards have accessed additional staffing through bank and agency. Recruitment continues for Band 5 vacancies with rolling advert, start dates awaited for 2 x Band 5 RGN's. Band 2 and 3 recruitment campaign completed, 3 successful applicants awaiting recruitment checks. Therapy team used on occasions to support ward team staffing.

Staff absence across the CBU has decreased slightly from 8.92% in October to 8.27% in November, although inpatient sickness levels range from 8.98% (Ward 2) to 14.65% (Ward 4). Ward managers continue to work closely with PAM, staff wellbeing services and Workforce to ensure support and facilitation of return to work at earliest opportunity.

South Locality Multidisciplinary Team Staffing Summary

	Staff in post	Vacancies
Inpatient CBU		
Physiotherapists	8	0
Occupational Therapists	HWP- 14 MWM	0 1
Psychologists	9.7	4.5
Speech and Language Therapy	5	0
Exercise Therapy		1
Dietitians – Inpatients	0.0	0.6
Speech and Language Therapists – Inpatients	4.1	3.4
Neuro & Specialist CBU		
Physiotherapists	12.5	1 Band 6 Mat Leave
Occupational Therapists	14.2	2 band 6 Mat Leave
Psychologists	7.8	1 Band 4 Mat Leave 1 Band 8c
Dietitians – Neuro	4.9	0.0
Speech and Language Therapists – Neuro	5.8	0.0

Recruitment & Retention:

Inpatient CBU: Recruitment campaigns are ongoing for the South Locality, with representation on the Trust-wide Values-Based Recruitment meetings. A central recruitment campaign is now in place, an internal/external advert will continue to be advertised for Registered Nurses. The South locality advert was developed and went live at the end of August. The first batch of applicants form the central advert were shortlisted and 10 were successful in recruitment. It is noted that 9 of the applicants are new qualifiers who are due to complete their training in March 2022. A further 6 candidates from the central advert were shortlisted in October with 5 being successful. This process continues to draw in applicants both internal and external which is supporting some of the vacancies on the wards. The South are planning to take part in the 'Zero Health Care Support Worker Project'. This programme is to support our HCSW recruitment, minimise vacancies, avoid reliance on temporary staff and so provide greater continuity of care for patients. This is planned to take place in January we are arranging meetings with 'indeed.com' that are supporting the process.

Neuro & Specialist CBU: Temporary 12 months 0.8wte Band 6 OT interviewed and appointed to and awaiting HR checks. Band 7 Clinical Lead successful on gaining secondment with NHSE, therefore internal recruitment process commenced for secondment cover.

Developments:

Inpatient CBU: Workforce plans within all wards are being reviewed to support the development of our workforce. New opportunities have been developed with consideration on what will add the greatest value to enhance the experience of patients and carers. In some areas this includes looking at additional resources in existing provision, in particular exercise therapy, psychology, occupational therapy and speech and language therapy. We are also reviewing with the enhanced provision, can specialities operate over 7 days not just Mon-Fri 9-5.

Neuro & Specialist CBU: Development of CPD opportunities for RGN's to help make posts more attractive.

Medical Workforce Summary

On a monthly basis the Trust wide Medical Managers Meeting receives a comprehensive report on the Medical Staffing position where this is discussed and debated. A summary of these reports as below provides the Trust position by CBU for November 2021. It is anticipated that the future arrival of a number of international Doctors will help improvements through further reducing the vacancy factor Trust-wide.

Locality	CBU	2021/22 Budget	Monthly Payroll	Add PA's	Agency	Vacancies
SOUTH	Access	6.37	5.30	0.90	1.80	1.63
SOUTH	Community	35.80	32.18	1.63	0.00	-1.99
SOUTH	Inpatient	17.77	17.92	0.70	2.70	3.55
SOUTH	Specialist	24.37	22.95	0.19	0.85	-0.38
SOUTH	**Total**	**84.31**	**78.35**	**3.42**	**5.35**	**2.81**
CENTRAL	Access	13.38	13.41	0.20	0.08	0.31
CENTRAL	Community	34.86	32.00	2.05	2.50	1.69
CENTRAL	Inpatient	12.80	11.95	1.17	1.00	1.32
CENTRAL	Secure	11.93	11.96	0.43	0.10	0.56
CENTRAL	**Total**	**72.97**	**69.32**	**3.85**	**3.68**	**3.88**
N.CUMBRIA	Community & Access	16.94	15.44	0.68	2.00	1.18
N.CUMBRIA	Inpatient	16.61	14.49	0.20	2.50	0.58
N.CUMBRIA	CYPS	14.86	10.86	0.72	0.60	-2.68
N.CUMBRIA	**Total**	**48.41**	**40.79**	**1.60**	**5.10**	**-0.92**
NORTH	Access	8.56	5.16	0.01	0.00	-3.39
NORTH	Community	32.72	27.50	1.18	2.30	-1.74
NORTH	Inpatient	14.35	14.87	0.78	4.00	5.30
NORTH	LD & Autism	4.60	1.80	0.10	2.20	-0.50
NORTH	**Total**	**60.23**	**49.33**	**2.07**	**8.50**	**-0.33**
TRUST	**Total**	**265.92**	**237.79**	**10.94**	**22.63**	**5.44**

Trust-wide Values-Based recruitment and retention

The Recruitment and Retention Taskforce, led by the Chief Nurse, with Executive director specific areas of leadership, is focusing on identified priorities and is supporting measures being taken to improve the staffing position. This work is supported and operationalised by the Trust-wide Values-based recruitment group. This includes Central Recruitment, International Recruitment, recruitment premia / incentives, career progression opportunities and the development of a flexi-pool for students of all professional disciplines. An options appraisal relating to the timing and frequency of pay to bank staff members was undertaken. A formal internal rotation/ transfer process has also been introduced across the Trust. The priorities remain to protect inpatient staffing and to promote inpatient services as an attractive career pathway for Registered Nurses and Doctors.

Six Monthly Skill Mix Review

North Cumbria:

North Cumbria- Inpatients: Workforce plans and skill mix have been subject to continuous review with active recruitment throughout the pandemic. The skill mix within the wards are multi professional and support the wider Trust workforce plan. We have recruited to numerous Nurse specialist post and are out to advert for an inpatient matron to support the nursing core element with our staff groups. We have increased band 6 Clinical lead posts across all wards to support a senior nursing workforce model alongside senior OT posts as part of the enhanced inpatient teams. We have successfully recruited to several HCA posts and are engaged in International

recruitment interviews to support a cohort of nurses being placed in North Cumbria. In addition, we are working with UCLAN in west Cumbria offering schools the opportunity to meet with nursing staff to enable and attract nursing as a vocation.

The CBU vacancies remain consistently high at band 5 level.

The locality continues to recruit Peer, carer and senior peer support workers with a positive effect in all teams.

Specialist CYPS- Inpatients: Specialist CYPS inpatients have experienced a loss of experienced registered staff over the past six months. In response the CBU has offered development opportunities at both band 6 and band 7 to registered staff to encourage retention of their expertise. In addition, the staff consultation process as part of the CEDAR project has impacted on retention of non-registered staff. Following the proposed adoption of a new shift pattern there were a number of objections from non-registered staff who have subsequently pursued alternative employment through the redeployment process or who have sought employment in other services both inside and outside of the organisation. The reduced number of regular staff has then in turn reduced the ability to offer opportunities as an incentive to remain in inpatient services.

Skill mix is reviewed daily during the staffing huddle, during the meeting the ratio of regular and non-regular staff on all wards is considered and staff are redeployed to create a balance wherever possible.

Recruitment of registered nurses remains a challenge. Campaigns are on-going but have had very limited success. In an attempt to improve numbers of regular staff there has been three rounds of band 3 interviews. A number of staff have been successfully appointed but there have been some challenges in obtaining clearances to get staff into post.

North:
The Inpatient CBU skill mix remains largely unchanged although we recognise that we will continue to use increased numbers of unregistered nurses to mitigate the national and local shortage of Registered Nurses whilst recruitment continues. The Learning Disability and Autism CBU has begun a focused piece of work to increase the Registered Nurse provision (currently 12%, Nurse Associates 3.5% and Nursing Assistants 84.5%) over the next 18 months to be more appropriately spread. The length of time recognises the significant challenges that this will see given the number of learning disability nurses qualifying at points through academic years, this piece of work will include working with partner local universities and our Academy.

Central:
Central have had a reduction in qualified staffing level below safer staffing for at least the past 6 months. To support this we have increased the numbers of band 3 support workers via bank and agency. We have also used the Enhanced MDT to support the ward teams, so OT staff for example working more into the wards, providing increased group work and therapy based activity. We have increased the numbers of assistant psychologists on the ward again to provide therapeutic group work and 1:1 engagement with patients. In addition, Nurse Consultants are also working clinically across the locality.

More recently we have recruited into further OT posts and assistant psychology posts on short term contracts until the end of March, to work into the ward shift patterns, to help with the quality provision given the nursing shortages, but to also work towards a more enhanced MDT way of working.

We also have rolling adverts out for band 3's to 6 for nursing staff.

South:

Inpatient CBU: Workforce plans and skill mix have been subject to continuous review throughout the pandemic. The skill mix within the wards are multi professional and support the wider Trust workforce plan. The ongoing national shortage of registered nurse staff are reflected within the vacancies in Inpatients. Over the last six month we have focused on registered nurse retention with the aim to reduce turnover. To support this we have reviewed Exit Interviews for staff moving within the Trust or leaving the Trust. A key theme often cited is progression to higher grade. Progression for registered nurse staff are naturally limited by the ward establishments, e.g. 67% are Band 5, 22% Band 6 and 11% Band 7.

Workforce plans have however been reviewed and new roles developed to, support progression opportunities, reduce the turnover of staff and improve the patient and carer experience. This has included the introduction of Band 7 senior Clinical Lead Nurse on the wards, a role distinct to the Band 7 Ward Manager as it has a distinct clinical leadership focus on safety, quality and continuous improvement.

The Adult Acute wards have increased the number of Band 6 Clinical Leads per ward, this offers further progression opportunities.

Another area of focus has been using different disciplines to enhance the MDT on the ward. Each time a vacancy arises we do not necessarily appoint 'like-for-like' instead it is an opportunity to consider the clinical need, risks and the skills or competency gaps that need to be addressed as part of the post identified for recruitment i.e. best fit for the ward. This has seen the skill mix being enhanced by additional Occupational Therapists, Speech and Language Therapists, Exercise Therapy Higher Psychology Assistants.

Within the last 6 months we have seen the consolidation of Nurse Consultants in all inpatient areas, Older persons, Learning Disability, Rehabilitation and Recovery and Adult Acute and PICU which has improved patient care whilst maintaining safety and promoting quality improvement, it has allowed an expert practitioner to input and support patients carers and staff. The Nurse Consultants are also either non-medical approved clinicians or working towards this qualification. This is particularly significant in relation to the difficulties in medical recruitment in that their skills are complementing the wider Multidisciplinary Team.

All 12 wards within Inpatients have introduced the Peer Supporter role in ward establishments. This role has supported patient and carer experience through the uniqueness of their lived experience and recovery which helps promote hope and recovery. Some wards are considering additional peer supports to provide this role 7 days.

The CBU continues to support staff in Trust initiatives to facilitate pathways into Nurse Training. Using CNTW academy to support access to service specific vocational qualifications: Foundation Degrees and access to flexibly delivered pre-registration education BSc (Hons) Mental Health Nursing. Staff have been successful in apprenticeship programmes who are supported on placement and then return as a Band 5 preceptees.

Neuro & Specialist CBU: While a full staffing review across all wards has not been undertaken, establishments have been continuously reviewed throughout the pandemic. In addition the CBU have used the opportunity as part of the data collection work for the Allocate rollout to review establishments. This has taken place with the clinical team, finance colleagues and Associate Nurse Director and Associate Director.

As a result, Gibside have introduced a Clinical Lead Band 7 role as a pilot and also an increase in Band 6 provision (from 1 to 2 posts). This is funded by a slight reduction in Band 5 nursing, but as

having been unable to meet the existing establishment, this hopefully creates an opportunity to enhance retention. The rationale is around visible leadership, career progression and succession planning. The 12 month pilot will be evaluated using pre and post questionnaire with whole team including wider MDT.

Beadnell have also progressed with a Band 7 Clinical Lead post. This has been piloted for over 12 months with positive outcome and secured funding to make this a permanent post. Although not a change to structure, the CBU are looking to reconfigure safer staffing numbers to exclude Nursery Nurses from the data as they provide therapeutic intervention.

The locality plan to review safer staffing numbers across Walkergate Park wards and 31a in a similar way in the coming months with consideration given to clinical Band 7 posts. In addition actions have been taken re CPD opportunities for RGN's with a view to making these posts more attractive.

Conclusion

The 6 monthly update on Skill mix review demonstrates the continuous attention to develop roles and respond innovatively to the changing workforce profile as well as the changing models of service provision.

The report also provides assurance on Safe Staffing Levels, via continuous risk assessment with respect to changing clinical need and levels of acuity, supported by ward team safety huddles and sitrep meetings. Adjustments have been made as necessary to ensure that patient safety is not compromised and that any risks are escalated appropriately. The report highlights the significant collaborative work undertaken during the Covid-19 pandemic to ensure staffing levels remain safe during a further surge in Covid-related pressure. This was supported by the Ensuring Operational Delivery meetings, which continued throughout November. The Report also highlights the risks associated with ongoing Covid and non-Covid-related absences and the continuing vacancy factor.

Anne Moore, Group Nurse Director, Safer Care
January 2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting
Wednesday 2nd February 2022

Title of report	**Integrated Care System: Approach to Place-Based Partnership Arrangements**
Report author(s)	**James Duncan, Chief Executive**
Executive Lead (if different from above)	**James Duncan, Chief Executive**

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

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

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

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

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

Integrated Care System: Approach to Place-Based Partnership Arrangements in Sunderland

Executive Summary

To seek the Board of Directors approval of the approach to collaborative partnership arrangements to integrate health and care commissioning and delivery in Sunderland in readiness for the establishment of the Integrated Care System as a statutory body from 01 July 2022.

Key points to note

- Subject to the passage of the draft Health and Care Bill clinical commissioning groups (CCG) will cease from 30 June 2022 and be replaced by integrated care boards (ICB).
- To allow sufficient time for the remaining parliamentary stages, a revised target date was announced on 24 December 2021 for the new statutory arrangements to take effect. ICBs are now expected to be legally and operationally established from 01 July 2022 (3 month delay).
- The statutory functions and relevant duties of CCGs will be transferred to ICBs.
- ICBs are required to publish a scheme of reservation and delegation in relation to the functions reserved to the ICB and those it would distribute to place-based partnerships.
- Place-based arrangements between the NHS, local authorities and providers of health and care are to be left to local areas to arrange.
- Over the proceeding months, the North East and North Cumbria Integrated Care System (NENC ICS) has engaged on its development, including its operating model.
- The NENC ICS is proposing that delegated ICB functions and NHS resources distributed to place level would be managed by an individual executive director of the ICB (Executive Director of Place Based Delivery) working within existing partnership arrangements established within all 13 places within the NENC ICS.
- A formal place-based partnership will need to be in place in Sunderland from July 2022 to work with the NENC ICB.
- The Trust is already working informally with Sunderland City Council, its local NHS hospital, CCG colleagues and wider partners. The current arrangements are described in the report.
- The report proposes formalizing the current partnership arrangements underpinned by a memorandum of understanding (referred to as Place Agreement).
- Once the ICB is in its statutory form, place-based partnerships would have the opportunity to propose longer term governance arrangements. The report outlines the intention longer term to establish a joint committee between the ICB, the Council and partners.

Risk and issues to note

Due to the time required for the passage of the Bill to get Royal Assent, there is the risk that the ICB would not be established by the national deadline set by the government.

There is a potential risk to effective partnership and stakeholder working at place and a consequent failure to deliver statutory functions due to a lack of clarity on delegation and decision-making processes.

Assurances

A number of workstreams have been set up at a Sunderland system level to progress the areas needed as part of the transition process and include key CCG representatives. The workstreams are being overseen by a Transition Steering Group, a partnership group of executive representatives from the NHS, Council and partners which reports to Sunderland's Integrated Care Executive, led by Chief Executives from Sunderland CCG, Sunderland City Council, South Tyneside

and Sunderland NHS Foundation Trust, Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust and All Together Better.

To formalise the current, collaborative partnership arrangements would ensure continuity and stability.

Recommendation

It is recommended that the Board of Directors:

- **Approve the approach to formalise Sunderland's place-based partnership arrangements, as set out in the report; and**
- **Receive the Place Agreement (MOU) at a later date for approval, once this is finalised.**

James Duncan
Chief Executive

INTEGRATED CARE SYSTEMS: APPROACH TO PLACE-BASED PARTNERSHIP ARRANGEMENTS

1. Purpose of the Report

1.1 The report seeks the Board of Directors approval of the approach to collaborative partnership arrangements to integrate health and care commissioning and delivery in Sunderland in readiness for the establishment of the Integrated Care System as a statutory body from 01 July 2022.

2. Background

2.1 The Health and Care Bill ('the Bill') was laid before Parliament on 6 July 2021. The Bill introduces new measures to promote and enable collaboration in health and care and key elements are as follows.

2.2 Subject to the passage of legislation the statutory integrated care system (ICS) arrangements would comprise: an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP).

2.3 The ICBs will be directly accountable for NHS spend and performance. Draft legislation and interim NHS England/Improvement policy guidance require each ICB to set out its governance and leadership arrangements in a constitution following an engagement process with clinical commissioning groups, local authorities and other partners.

2.4 The ICPs will operate as a forum to bring partners – local authorities, NHS and others - together across the ICS area to develop a plan to integrate care and address the broader health, social care and public health needs of their system. The membership and detailed functions of the ICP will be up to each ICB to decide.

2.5 From July 2022, the ICBs will replace existing clinical commissioning groups (CCGs). The CCGs' statutory functions will be conferred on ICBs, including commissioning responsibilities. Relevant CCG duties will also be transferred to ICBs, including those regarding health inequalities, quality, safeguarding, children and young people with special education needs or disability.

2.6 ICBs will be required to publish a scheme of reservation and delegation in relation to functions that are reserved to the ICB and the functions it would distribute to place-based partnerships.

2.7 Currently the Bill avoids a nationally mandated approach to place level arrangements. Place based arrangements between local authorities, the NHS and providers of health and care will be left to local areas to arrange.

2.8 Health and Wellbeing Boards will continue to undertake their important role in local places. NHS provider organisations will remain separate statutory bodies, retain their structures and governance and be expected to work collaboratively with partners.

3. Current Position

North East and North Cumbria Integrated Care System

3.1 Sunderland is part of the North East and North Cumbria Integrated Care System (NENC ICS), a regional partnership of 13 local authorities, 8 CCGs, 12 NHS Foundation Trusts and wider partners.

3.2 The NENC ICS has engaged on its development during the summer and through a series of meetings with executive leaders from local authorities and the NHS during October, November and December 2021. The NENC ICS is designing its operating model including the functions the ICB would reserve to discharge at system level and which functions it would distribute to the 13 places working with place level partnerships.

3.3 National guidance sets out ways in which functions delegated from the new ICBs to places might be organised. The guidance is covered in three publications: *Integrated Care Systems: Design Framework* (June 2021) and *Thriving Places: guidance on the development of place-based partnerships as part of statutory Integrated Care Systems* (September 2021) and Integrated care boards: guide to developing a Scheme of Reservation and Delegation The guidance offers five broad, place-based governance options that could be established by the ICB together with local authorities and other partners at place level to drive and oversee integration

3.4 The NENC ICS is proposing in the ICB's draft constitution that the delegated ICB functions and NHS resources distributed to place level would be managed by an individual director of the ICB (Executive Director of Place Based Delivery) working within the existing place-based partnership arrangements.

3.5 The NENC ICS also proposes an evolutionary approach to developing the governance arrangements with place partnerships seeking, as far as possible, to continue partnership arrangements that operate at present to gain experience of the new system before decisions about new governance structures are made. Once the ICB is in its statutory form post July 2022, place-based partnerships across the ICS would have the opportunity, if they wish, to propose a longer-term governance model, possibly drawn from the national list outlined above.

Sunderland's existing partnership arrangements

3.6 A formal place-based partnership will need to be in place in Sunderland from July 2022 to work with the NENC ICB. The Council and its NHS partners are already working together informally to integrate health and care and to develop plans collectively to enable the organisations to achieve more than they can individually to improve health and care outcomes and reduce health inequalities in Sunderland.

3.7 Figure 1 illustrates the current partnership arrangements.

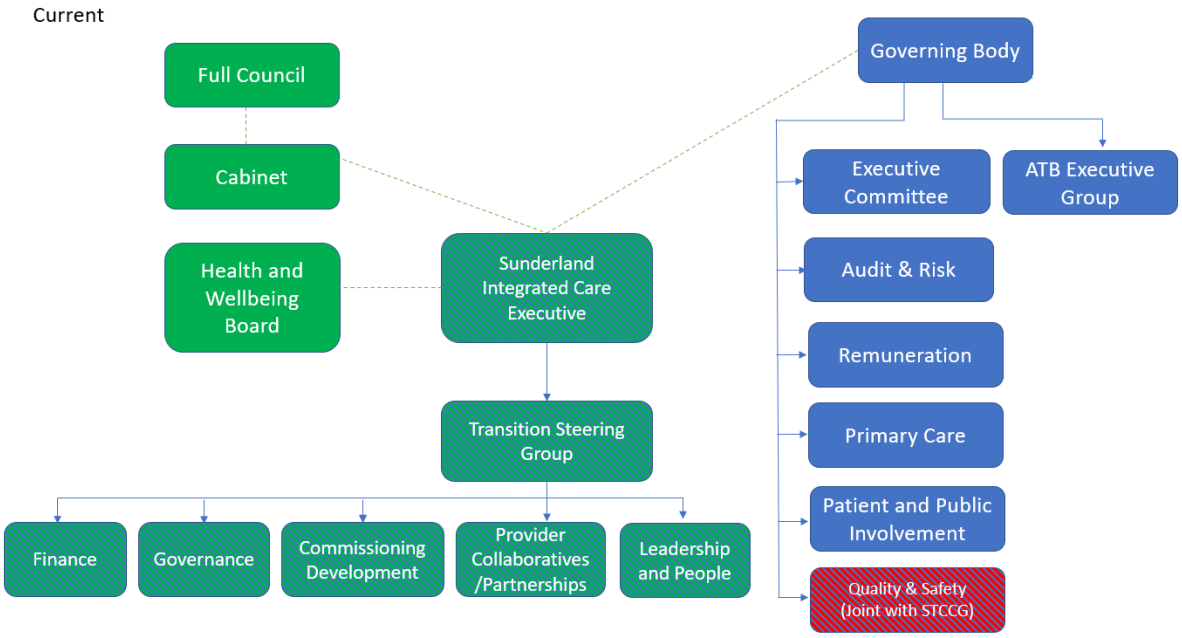


Figure 1

3.8 The Sunderland Integrated Care Executive ('the Executive') was established as a non-formal Partnership Executive to lead, provide direction, and support the transition to new place-based arrangements within Sunderland. It is led by Chief Executives from Sunderland City Council, Sunderland CCG, South Tyneside and Sunderland NHS Foundation Trust (FT), Cumbria, Northumberland and Tyne and Wear NHS FT and clinical chairs from Sunderland CCG and the All Together Better Alliance (ATB), Sunderland Council's Director of Public Health and Integrated Commissioning and Sunderland CCG's Chief Officer/Chief Finance Officer.

3.9 The Executive is supported by the Transition Steering Group (TSG), again a non-formal partnership group with executive representation from the Council, NHS and partners. The TSG Governance Group has led the development of Sunderland's partnership working arrangements as part of the future statutory ICS arrangements.

4. Future partnership governance arrangements in Sunderland

4.1 Figure 2 shows the evolution of the existing arrangements to deliver the vision and aims of the partnership as well showing how the partnership will work as part of the NENC ICS system governance.

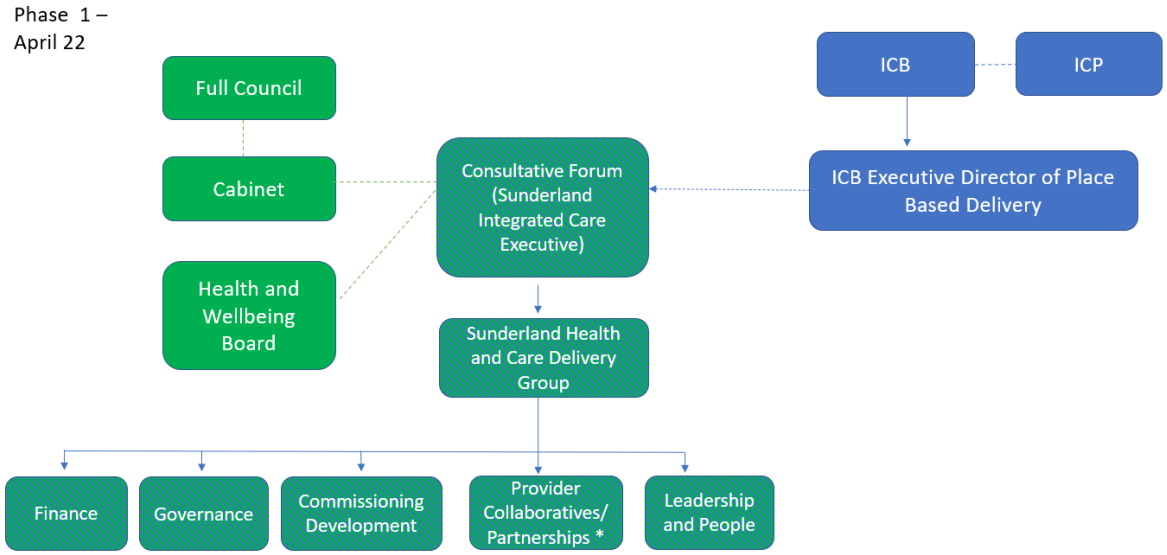


Figure 2

4.2 The Executive would develop into a Consultative Forum agreeing together the strategic direction for Sunderland and informing both local partners and the ICB's decisions from a strategic perspective. The current Transition Steering Group would develop into a Sunderland Health and Care Delivery Group to support the Consultative Forum to fulfil its functions and accountabilities.

4.3 The membership of the Consultative Forum, and Sunderland Health and Care Delivery Group, would be determined by the function of each. National guidance and the proposed longer-term approach to place arrangements agreed by the CCG/ICB and partners (section 5) will also influence the evolution of the membership.

4.4 Working with partners, the CCG/ICB and Council would develop and agree how the functions (for example, the monitoring of quality of local health and care services) might be discharged in practice at place level.

4.5 It is expected that the ICB Executive Director of Place Based Delivery would consult appropriately with the Consultative Forum and have due regard to its views when discharging the delegated functions and decision making in accordance with the ICB's Scheme of Delegation.

4.6 It is anticipated that the place-based arrangements shown in figure 2 would be in place during 2022/23 while work would continue to develop a formal proposal to the ICB for a longer-term governance model to underpin collaborative partnership arrangements to develop an integrated, all-age, place-based health and care system for Sunderland.

4.7 A draft Memorandum of Understanding (referred to below as a Place Agreement) has been developed to underpin and strengthen the partnership arrangements so that the Consultative Forum is able to discharge potential functions distributed to it by the ICB and deliver better outcomes through collaborative working.

Memorandum of Understanding / Place Agreement

4.8 The Memorandum of Understanding is intended to reflect the arrangements at "Place" level for collaboration between the partners. It will set out:

- Vision and aims of the collaborative partnership
- Key collaborative principles that partners will comply with when working together to achieve the vision and aims
- Governance structure underpinning the partnership
- Financial framework and financial principles to secure financial sustainability of partners
- Provisions for dealing with conflicts of interest and information sharing

4.9 The Place Agreement is designed to evolve over time (figure 3); this is particularly important during 2022/23 given the proposed developmental approach by the NENC ICS to place-based partnerships' governance arrangements in order to secure continuity of place-based working and gain experience of the new system before decisions about new governance structures are made.

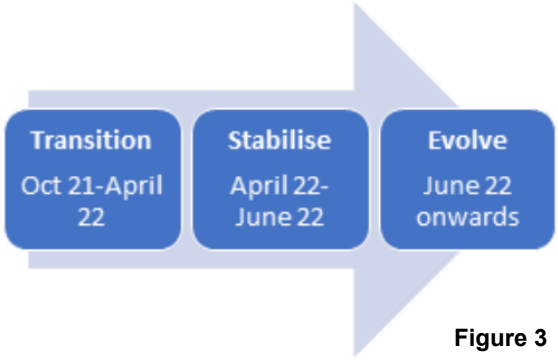


Figure 3

4.10 The Place Agreement is not a legally binding document. It will not override the existing statutory requirements/duties or governance arrangements of partner organisations, nor replace the decision-making processes of individual organisations.

4.11 The aim of the Place Agreement is to guide the work of partners at place, ensure decisions are based on what is best for the health and care system in Sunderland and for individuals receiving services and secure greater levels of health and care integration in commissioning and provision.

4.12 It is envisaged that the Place Agreement will be entered into and signed by the following partner organisations:

- Sunderland City Council
- Sunderland Clinical Commissioning Group
- South Tyneside and Sunderland NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

4.13 The Board of Directors will receive the Place Agreement for approval, once finalised.

5. Longer term approach to place level collaborative partnership working in Sunderland

5.1 Figure 4 illustrates the potential future arrangements which could be proposed to the NENC ICB during 2022/23.

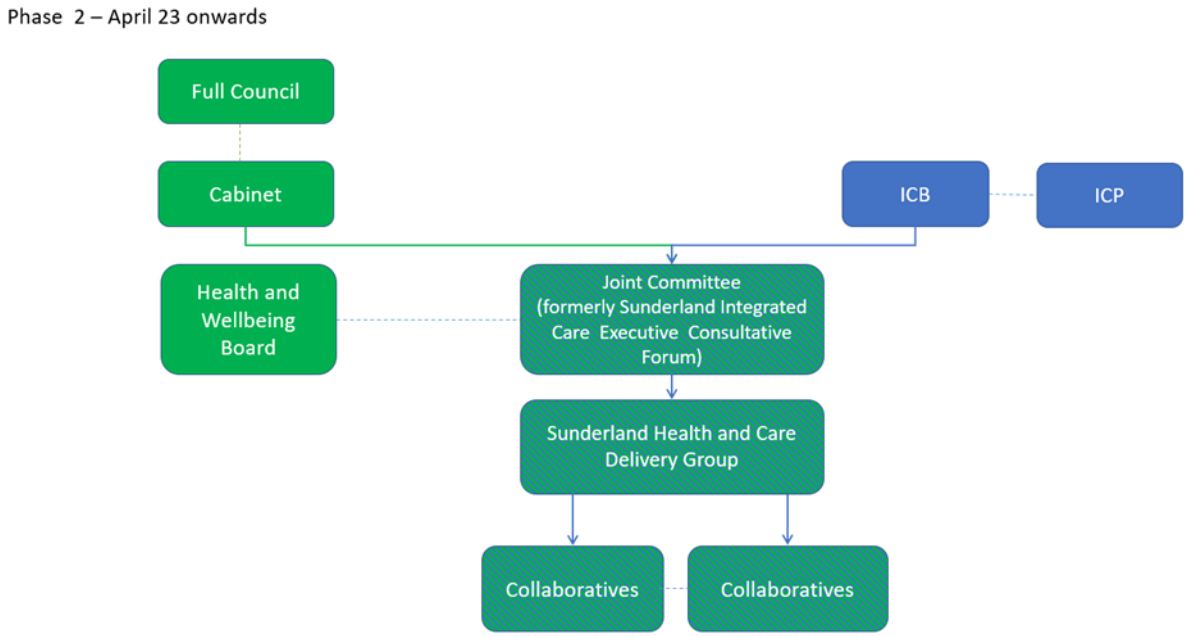


Figure 4

5.2 It is envisaged that the consultative forum would evolve into a joint committee between the ICB, Council and partners supported by a Sunderland Health and Care Delivery Group (sub-committee of the joint committee) and collaboratives, which could include a collaborative of NHS and Council commissioners as well as providers' collaboratives. However, this is subject to the Health and Care Bill being enacted as currently drafted and the relevant sections of that Bill, and subsequent secondary legislation, coming into force.

5.3 Future developments of the collaborative arrangements between the CCG/ICB and partners would be the subject of further reports.

5.4 The collaborative partnership arrangements proposed in sections 4 and 5 have been shared for comment and support with:

- The Health and Wellbeing Board,10th December 2021.
- The Health and Wellbeing Scrutiny Committee, 5th January 2022.

6. Next steps

6.1 To seek approval from Sunderland City Council's Cabinet of the place based collaborative partnership arrangements in readiness for the establishment of the Integrated Care System as a statutory body from 01 July 2022.

6.2 To seek support and endorsement for the proposed place-based partnership arrangements from statutory NHS provider partners, e.g South Tyneside and Sunderland NHS FT and Cumbria and Northumberland, Tyne and Wear NHS FT, subject to Council Cabinet and CCG Governing Body approval.

7. Recommendations

7.1 It is recommended that Governing Body:

a. approve the approach to formalise Sunderland's place-based partnership arrangements as set out in the report.
b. receive the Place Agreement at a later date for approval, once this is finalised.

Name of Sponsoring Director:
James Duncan, Chief Executive, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to Board of Directors
2nd February 2022

Title of report	**Update on CQC Must Do Action Plans (Quarter 3)**
Report author(s)	**Vicky Wilkie, CQC Compliance and Governance Manager**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning and Quality Assurance**

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

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	26/01/22
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	24/01/22
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA5: The Trust will be the centre of excellence for mental health and disability. Risk 1688 Due to the compliance standards set from NHSI, CQC and legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements. Risk 1691: As a result of not meeting statutory and legal requirements regarding mental health legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.

Update on CQC Must Do Action Plans

Board of Directors

2nd February 2022

1. Executive Summary

This report provides an update on the 30 remaining areas of improvement (Must Do action plans) which were received following inspections undertaken during 2015, 2017, 2018, 2019 and 2020. 21 areas of improvement have been closed by the Board of Directors since August 2020, 4 of which were reopened during July 2021 as they related to staffing levels.

- Through this report the Board are asked to extend further those Must Do action plans relating to restrictive practice, seclusion and long term segregation, physical health and rapid tranquilisation, documentation of consent to treatment/capacity and management supervision to enable further assurances to be gained that there has been an improvement.

- The Board are asked to note the re-opening of the Must Do action plan in relation to reducing out of area placements (see page 22).

- Work continues to address each of the remaining action plans specific to the North Cumbria Locality and those relating to the 2020 focused inspections (wards for people with learning disabilities or autism and child and adolescent mental health wards). These action plans continue to be monitored through the Locality Care Groups and Trust governance structures. Key pieces of work identified in the Quarter 3 update (**appendix 1**) will help to mitigate against the risks which have been raised.

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

2. Risks and mitigations associated with the report

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

3. Recommendation

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

The Board are asked to:

- Approve the date extension for Must Do action plans relating to restrictive practice, seclusion and long term segregation, physical health and rapid tranquilisation, documentation of consent to treatment/capacity and management supervision to enable further assurances to be gained that there has been an improvement.
- Note the re-opening of the Must Do action plan in relation to out of area placements.
- Note the Quarter 3 updates on all 47 CQC Must Do action plans (including impact changes for those closed).

Author:
Vicky Wilkie, CQC Compliance and Governance Manager

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

24th January 2022

Must Do Theme: (1) Personalisation of care plans	**Lead: Vida Morris, Group Nurse Director**
Planned timescale for closure: 31 March 2022	
Community LD Year: 2015 Org: CPFT	The trust must ensure that care plans are person-centred, holistic and presented in a way that meets the communication needs of people using services that follows best practice and guidance.
Community OP Year: 2017 Org: CPFT	The trust must ensure that all patients have comprehensive and up to date care plans and risk assessments. Care plans and risk assessments must be regularly reviewed, and information must be used to inform each document.
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that care planning takes place with young people and is recorded in an accessible format that young people can understand. Care plans must be shared with young people and their carers where appropriate.
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that care plans contain the relevant supporting information, reflective of current need, regularly updated and that staff are aware of these and follow plans accordingly.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Roll out of visual materials i.e. posters and booklet. • Roll out of training materials commenced in June 2021. • Audit to be revisited pre and post new training materials to demonstrate any changes in practice. Audit commenced for pre training materials on 21/06/21 Trust-wide. • Train the trainers session completed.	
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):	
• Animations to support training completed and placed on share point. • Posters for clinical areas complete and awaiting printing. • Training roll out within priority areas (Learning Disability / Autism / CYPS) continues – stalled due to surge activity. To broaden to all clinical areas (Inpatient, Community, Access). • Training audit completed end of September / early October 2021.	
Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):	
• Posters have been received from printers and will be distributed during January. • Training tools evaluated positively for inpatient areas.	
Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):	
• Completion of training in all areas. • End of January 2022 – project close following final meeting to hand back performance management of care planning to CBUs / Locality Care Groups.	
Evidence of Impact:	
The metric for the number of current service users who have discussed their care plan remains similar to the Quarter 2 position: • North Cumbria Locality – 82% (September), 82% (December) • North Locality – 94% (September), 95% (December) • Central Locality – 93% (September), 92% (December) • South Locality – 89% (September), 90% (December) Care planning was identified as an issue in 3 of the 8 wards visited by MHA Reviewers during Quarter 3.	
Status:	
Ongoing further action required to make improvements.	

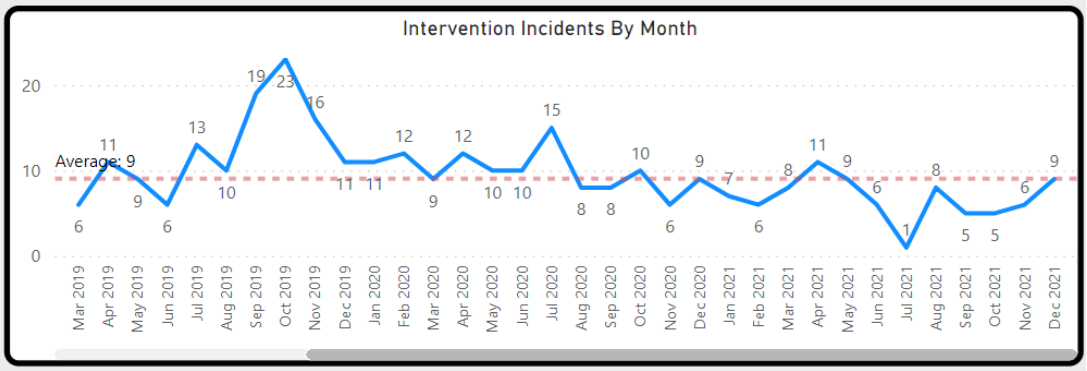
Must Do Theme: (3) Restrictive practices, seclusion and long term segregation	Lead: Anthony Deery, Group Director & Ron Weddle, Deputy Director – Positive and Safe
Planned timescale for closure: 31 December 2021 (31 March 2022)	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff complete body maps and carry out and record physical observations following the use of restraint and ensure that there is a rationale recorded for any 'as required' medication being administered following the use of restraint.
Planned timescale for closure: 31 December 2021 (31 March 2022)	
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that the patients in long term segregation and seclusion have the appropriate safeguards in place in accordance with the Mental Health Act Code of Practice and these are documented clearly in patients' records
Planned timescale for closure: 30 June 2021	
LD & Autism wards Year: 2020 Org: CNTW	The trust must review and reduce the use of mechanical restraint within their learning disability services and ensure that its use is in line with best practice guidance and the appropriate authorisation and recording is in place
Planned timescale for closure: 31 December 2021 (31 March 2022)	
CAMHS wards Year: 2020 Org: CNTW	The Trust must review the use of restraint and mechanical restraint in the Children and Young People's Inpatient Services. The use of mechanical restraint should be used as a last resort in line with Department of Health Positive and Proactive Care. There should be a clear debrief process for the team after an incident and for the person who has been restrained.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
LD and Autism wards 2019	• Further work to be completed to identify if the body map could be available as part of RiO rather than ward staff having to upload a separate document • A smaller monthly audit to be implemented on selected cases to monitor change with a further full audit to be repeated in 3 months. • Consider during Quarter 1 whether audit should be carried out Trust-wide.
LD and Autism wards 2019	• The newly established Empower Programme Board will coordinate all actions in relation to restrictive practices. • The formal membership and articulation of priorities for each of the 4 elements (HOPEs model, Positive and Safe, Human Rights and Trauma Informed approaches) to be developed during Quarter 1 and Quarter 2. • Areas which are already contributing to reducing restrictive practices are elaborated below: – Continue to establish and embed the LTS and Prolonged Seclusion panels and review its impact on restrictive practices within the Trust. – Embed the Clinical Ethical Group and disseminate any Trust-wide learning. – Further embedding of Safety Pods. – Continue to roll out PAUSE training at Trust induction during Quarter 1 and 2. – Continue to offer Post Graduate Certificate in Reducing Restrictive Interventions which is a joint development by CNTW, TEWV and Cumbria University – current cohort of

	staff qualified in September 2021 and the next course is already significantly over subscribed.
CAMHS wards 2020	• Review of policy – format of debrief/post incident support to be altered to reduce to four questions (Is everyone safe, what happened, what went well, what do we need to do differently or what did we learn). Completed with Trust-wide representation. • Short training session to be incorporated into supervision agenda to ensure application of policy. • Formal audit tool and baseline assessment completed. • RiO – support to link debrief into case note / progress notes – action to be carried forward into Quarter 2 and 3.
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):	
LD and Autism wards 2019	• A scoping meeting to be held with identified lead to review audit tool and timescale for rolling out Audit Trust-wide. • Communication to all staff regarding the Policy, reinforcing the need for body maps after each incident of restraint. • North Cumbria has implemented a draft Audit, the first results have been completed and shared with teams and these have been reviewed within the CBU's. • Audit Tool has been agreed and communication developed to help the localities understand what needs to be recorded.
LD and Autism wards 2020	• The Long Term Segregation and Prolonged Seclusion Review Panel is in place and will continue to, review cases across the Trust on a weekly basis, provide assurance to the Board and promote learning across the Trust around this area of practice. • With the exception of Mitford within autism services, MRE continues to reduce within learning disability pathways across the Trust. • The first meeting of the Empower Board was held on 20 July 2021 where updates were received from the four work stream areas including Long Term Segregation, Positive and Safe, Human Rights and Trauma Informed Approaches. • Plans have been identified to progress each of the priorities in the work stream areas. • Trust Innovation will be liaising with the work stream sponsors to project manage the programme.
CAMHS wards 2020	• Amendments to Policy and new templates to be submitted and agreed by Policy owner. • Supervision crib sheet re carrying out debrief to be agreed and circulated. • Pictorial debrief to be included within appendix. • Audit to be carried out to measure fidelity to Policy.
Actions taken at core service level during Quarter 1 21/22 (April, May & June):	
CAMHS wards 2020	• All staff to be trained in the CNTW Empower Programme which brings together initiatives such as Positive and Safe, Human Rights, Trauma Informed Care and HOPEs Model and will ensure the roll-out of this methodology across all Children and Young People's services. Three staff members have enrolled for HOPEs training, one at each CYPS inpatient site. Training begins week commencing 28/06/21. • Individualised care plans continue to be reviewed and discussed in multi-disciplinary meetings; this includes patient and carer involvement, and will be evidenced and audited.

	• Clinical Lead Nurse continues to provide scrutiny and case load supervision to improve compliance with safeguards and embed review process. • CBU continue to review the de-brief process to ensure a robust de-brief happens after each incident of restraint, for both staff and young person involved. Clinical Nurse Managers to review the debrief process with a view to ensuring the full post incident review process happens after every incident.
Actions taken at core level during Quarter 2 21/22 (July, August & September)	
CAMHS wards 2020	• Identified staff will attend HOPEs training. • The training programme for the CAMHS accredited training continues and a programme for staff attending has been agreed. The next cohort of CYPS accredited training to start in August 2021. • A process was implemented following the inspection where it was agreed that an After Action Review would take place after each MRE incident. At a recent review it was recognised that there were issues around the operational implementation and monitoring of the process. A robust process will be implemented and monitored through CBU and locality Quality Standards meeting. • Clinical Nurse Managers continue to carry out audits of all post incident debriefs and review the quality and frequency to ensure that these occur after every incident and that the standards are always as we would expect. Where debrief is declined by the patient there is an attempt to engage the patient in an informal discussion and reflection on the incident by nursing staff. • On occasions where staff decline de-brief this is addressed as part of clinical supervision to encourage engagement and also provide the opportunity for staff to have an informal debrief through discussion with their supervisor. • Debrief processes require further embedding and from July 2021 incidents and debriefs are to be reviewed monthly as part of the CYPS operational and governance meetings and presented quarterly to the locality Quality and Safety meeting.
Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):	
LD and Autism wards 2019	• Body map documentation added onto RiO. • Audit tool has been agreed and initial Audit will be carried out in October/November 2021.
LD and Autism wards 2020	• All Long Term Segregation and Prolonged Seclusion patients across the Trust have been reviewed by the review panel. The panel will continue to review cases across the Trust on a weekly basis. • Work continue with the Empower Programme which is being supported by NTW Innovations. • Review/revision of the Trusts Seclusion Policy is taking place.
CAMHS wards 2020	Restrictive practices, MRE: • During Quarter 3 HOPEs training continued to be rolled out. • The Empower Board, jointly led by Dr Rajesh Nadkarni and Gary O'Hare, is established on a monthly basis. Work stream Leads and locality representatives are coming together to collaboratively discuss areas of focus, and streamline the interfaces of the Empower initiatives, forming under the work streams of Positive and Safe, Trauma Informed Care, HOPEs, and Human Rights.

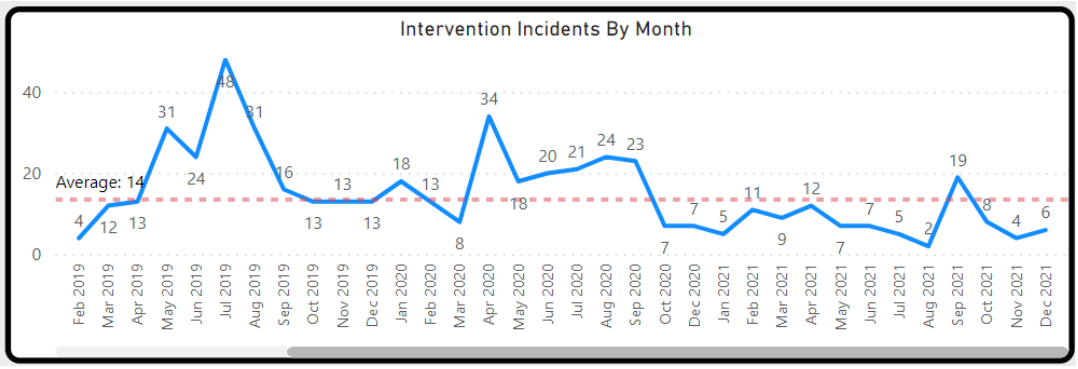
	Progressively, all leads are now confirming a set of priorities, which form into plans on rolling out the Trust-wide approaches in the coming months, some in the form of pilot schemes. Incident debriefs: • Post incident support work completed and incident debrief information can now be recorded on RiO. • Audit tool considered within working group and has been revised. • Further working group scheduled to review training needs for staff group to be confident in facilitating high quality debrief. • Trust Policy has been ratified. • End of Quarter 3 - dashboard to be developed to performance manage debrief recording.
CAMHS wards 2020	• MRE monitored weekly by the Clinical Manager for Quality. There had been a reduction in MRE use until September 2021 when MRE increased due to the patient group at Alnwood. • Work commenced locally in relation to debriefs to understand figures and recording processes in place. MRE use and debriefs are being monitored in weekly CYPS safety huddles.
Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):	
LD and Autism wards 2019	Audit of body maps to commence during January 2022. This was delayed from the original date due to Covid-19 and could be delayed further due to the Trust moving to Opel 3 on 5 January 2022.
LD and Autism wards 2020	• Long Term Segregation and Prolonged Seclusion review panels continue across the Trust on a weekly basis. • Work to continue with the Empower Programme which is being supported by NTW Innovations including roll out of HOPEs training during Quarter 4. • Review/revision of the Trusts Seclusion Policy to continue into Quarter 4.
CAMHS wards 2020	• Dashboard to be developed to monitor performance of debrief recording Trust-wide.
CAMHS wards 2020	• Debriefs are not being completed consistently by ward staff following incidents. • Associate Nurse Director has met with Ward Managers and Clinical Managers in November 2021 to establish a unified process for conducting and recording debriefs and reviewed any barriers which may have prevented the debriefs taking place. • Point of contact rota for debrief facilitators to be established. • Further meeting planned for January 2022 to address ongoing inconsistency, to include ward clerks • Wards to identify debrief champion role.
Evidence of Impact:	
Current episodes of Long Term Segregation/Prolonged Seclusion per core service: • Child and Adolescent Mental Health Wards – 5 • Wards for people with a learning disability or autism – 3 • Forensic inpatients or secure wards – 2 • Acute wards for adults of working age and PICU – 3 • Long stay rehabilitation ward for working age adults – 1	

MRE use across Learning Disability and Autism wards:



There has been a noted increase in MRE use during December 2021, of which the majority of incidents is attributed to one individual on Mitford. This person has an active MRE care plan in place that is agreed and governed by CNTW Directors. MRE use is used to support the transfer of this person to an alternative environment whilst their flat is being cleaned.

MRE use across Child and Adolescent Mental Health wards:



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

- Ashby
  In December 2021, 43% of staff debriefs were completed, 57% were not offered and 0% were declined. 27% of patient debriefs were completed, 56% were not offered and 17% were declined.

- Lennox
  In December 2021, 17% of staff and patient debriefs were completed. A total of 83% of debriefs for staff and patients were not offered. 0% were declined by staff and patients.

- Lotus
  In December 2021, 0% of staff debriefs were completed. 60% of patient debriefs were completed, 40% were offered but declined by patients.

- Ferndene wards
  December debrief data is not available for all wards at Ferndene due to ward moves and staff shortages impacted by Covid-19.

No restrictive practice/debrief compliance issues were identified within MHA Reviewer visits during Quarter 3.

Status:	
LD & Autism wards Year: 2019 Org: CPFT	It is requested that an extension be given to 31 March 2022 for this Must Do action plan so an initial audit can be carried out during Quarter 4.
LD & Autism wards Year: 2020 Org: CNTW	Closed by Board of Directors on 4 August 2021.
LD & Autism wards Year: 2020 Org: CNTW	It is requested that an extension be given to 31 March 2022 for this Must Do action plan to allow further improvements in relation to Long Term Segregation and Seclusion safeguards.
CAMHS wards 2020	It is requested that an extension be given to 31 March 2022 for this Must Do action plan to allow further improvements in relation to incident debrief compliance.

Must Do Theme: (4) Appraisal and training	**Ramona Duguid, Chief Operating Officer Supported by: Marc House, Head of CNTW Academy**
Planned timescale for closure: 31 March 2022	
Community LD Year: 2015 Org: CPFT	The trust must ensure that all staff have an annual appraisal.
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that staff complete the mandatory training courses relevant to this service in line with trust policy to meet the trusts training compliance targets.
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that staff complete their mandatory and statutory training.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Rollout for the New Appraisal Policy and training package developed. • The Academy will continue to offer relevant and sufficient training places to meet the targets required and support staff to access e-learning. • Training continues to be offered via Teams where face to face is currently not viable due to current restrictions on work practices.	
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):	
• During 21/22 there has been a concerted effort throughout the organisation in both clinical and non-clinical service areas to ensure high levels of training compliance within the mandatory training fields with a particular focus given to achieving the Information Governance compliance level of 95% by the end of June 2021 (this has been achieved). In addition, we are producing a report from the dashboard which confirms monthly those staff who will be non-compliant in their Information Governance training, this will allow for ongoing monitoring rather than a once a year annual focus. • Having reviewed the current Accountability Frameworks along with the training dashboards it has been agreed that the following areas will have a particular focus during Quarter 2: Appraisals, Fire, Safeguarding Children level 3, Mental Health Act / Mental Capacity Act / DOLs. • Every week bespoke data will be obtained on these four priorities and considered by a representative group from clinical, corporate, and training departments. Progress against these training requirements will be shared with the responsible Directors on a regular basis. On the 14th July 2021 the Trust returned to Opel 2 and all training and appraisal were paused due to current staffing pressure.	
Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):	
Localities continue to adjust their trajectories in line with their progress.	

Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):
Continue to monitor against agreed trajectories.
Evidence of Impact:
• The standards for the following training courses remain above standard across all groups during Quarter 3: Health and Safety, Moving and Handling, Equality and Diversity, Hand Hygiene • The standards for the following training courses remain below standard across all groups during Quarter 3: PMVA basic training, Information Governance • The standards for the following training courses remain below standard in the North Cumbria group during Quarter 3: Fire, Clinical Risk, Clinical Supervision, Safeguarding Children (level 1, 2, 3), Safeguarding Adults, Medicines Management, MHCT Clustering, MCA/MHA/DOLS, Seclusion, PMVA Basic and Breakaway, Information Governance • The standards for the following training courses remain below standard in the North group during Quarter 3: Clinical Supervision, Safeguarding Children level 2, Rapid Tranquilisation, MCA/MHA/DOLS, Seclusion, PMVA Basic and Breakaway, Information Governance • The standards for the following training courses remain below standard in the Central group during Quarter 3: Fire, Clinical Supervision, Safeguarding Children level 3, MHCT Clustering, MCA/MHA/DOLS, PMVA Basic and Breakaway, Information Governance • The standards for the following training courses remain below standard in the South group during Quarter 3: MHCT Clustering, PMVA Basic, Information Governance • Appraisal compliance has deteriorated across the groups during Quarter 3: o North Cumbria Locality - 65% (September), 60% (December) o North Locality - 68% (September), 67% (December) o Central Locality - 71% (September), 65% (December) o South Locality - 80.6% (September), 79% (December) o Support and Corporate - 61% (September), 62% (December)
Status:
Ongoing further action required to make improvements.

Must Do Theme: (5) Clinical supervision	Lead: Dr Esther Cohen-Tovee, Director of AHPs & Psychological Services
Planned timescale for closure: 31 March 2022	
Community OP Year: 2017 Org: CPFT	The trust must ensure that all staff receive clinical and management supervision and that it is documented. The trust must ensure that supervision figures are shared appropriately with senior managers.
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues its development of staff supervision and the board have clear oversight of both quantity and quality of supervision.
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff receive regular supervision.

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

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

Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):

- Training video produced in August and made available to facilitate and support use of the online recording system via a 7 minute briefing presented to Trust Managers meeting on 19 August 2021 and subsequently circulated to all Trust Managers.
- Revised user guide and FAQs was also produced and circulated through the 7 minute briefing described above.
- CSOG discussed ways in which the system could be simplified, if acceptable in terms of governance. It was noted by the CSOG that the system that is in place is in fact simple and easy to use, and the view of the group was it would be more desirable to add additional detail. It was not thought that the system could be simplified while retaining the essential governance requirements and it was hoped that the additional supporting materials would support improved adherence and data quality.

Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):

- CBUs and Corporate clinical areas have continued to monitor their clinical supervision data on a regular basis and identify any teams or areas that may need support to improve adherence to policy and recording. Data quality issues are also being addressed.

• 7 Minute briefing regarding clinical supervision recording was shared with all staff through Safer Care Bulletin and has been cascaded to Clinical Management Teams. • CSOG representatives are working with colleagues on culture change where needed to support behaviour change to prioritise both the implementation of clinical supervision and its recording as per policy. There are some areas where value and quality have been questioned and these are being addressed.
Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):
• It is anticipated that the move to Opel 3 in January 2022 and the operational pressures will impact on clinical supervision uptake. It will certainly impact on clinical supervision training uptake because all non-essential training has been stood down while the Trust is at Opel 3. There is a particular pressure on inpatient services and innovative approaches to ensure availability of clinical supervision in this setting need to be developed. • Removal of staff who do not need to receive clinical supervision (e.g. due to being in a corporate role, being on bank only and not currently working, or where arrangements are managed externally e.g. trainees on the Clinical Psychology doctorate course at Newcastle University) will improve data quality. • Widening access to the dashboard data will assist CBUs in identifying and addressing any areas where there are problems with clinical supervision availability, uptake, or recording.
Evidence of Impact:
Current position as of 31 December 2021 (Including improvement √ or deterioration from last quarter): 48%: √ Medical Directorate 22%: √ Chief Nurse Directorate 35%: ↓ North Cumbria Group 42%: √ North Group 41%: ↓ Central Group 55%: South Group 65% √ AHP & Psychological Services 59% √ Pharmacy
Status:
Ongoing further action required to make improvements.

Must Do Theme: (7) Documentation of consent to treatment and capacity	**Lead: Dr Patrick Keown, Group Medical Director**
Planned timescale for closure: 31 December 2021 (31 March 2022)	
Community OP Year: 2017 Org: CPFT	The trust must ensure that consent to treatment and capacity to consent is clearly documented in patient's records.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• To undertake analysis of the data and information received as above and information to be taken for discussion at the Older Persons Strategic Clinical Network. • To request updated data with regard to capacity to consent (initiation and review of antipsychotics) to provide comparison • To review consent to treatment/capacity to consent within wider services across CNTW. Consent and Capacity to continue to be monitored via the MHL Steering Group.	
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):	
Work has been paused due to Covid-19 response.	

Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):
• To review within a task and finish group the various places on RiO that this information can be recorded and along with the RiO team explore whether there is another option for recording of consent to treatment and capacity to consent. • Within the task and finish group explore the contents of the consent to examination or treatment policy to establish whether this is being followed. Policy includes consent forms for completion including for those patients who lack capacity. • To establish if by using CRIS (Clinical Record Interactive System) we could extract data with regard to this issue from progress notes or other areas of the electronic record. • To undertake a mini audit of notes in Older People's community teams to assess compliance. • Leads identified for each locality to inform the internal audit of consent to treatment. Meetings are currently being held with leads to discuss the processes being followed in each locality for documenting capacity and consent for patients with dementia starting antipsychotic treatments and this will inform which parts of RiO are used to document this information.
Planned future Trust-wide actions to be undertaken during Quarter 4 21/22 (January, February & March):
Await the outcome of the internal audit which will help inform particular areas of concern in relation to this must do action i.e. various places this can be documented and compliance.
Evidence of Impact:
For the metric 916 – service users who had a discussion recorded at the point of their detention, there has been an improvement during Quarter 3 within North and Central localities. In North Cumbria and South localities there has been a deterioration of compliance. • North Cumbria Locality – 70% (September), 45% (December) • North Locality – 63% (September), 71% (December) • Central Locality – 44% (September), 68% (December) • South Locality – 79% (September), 73% (December) Issues with consenting to medical treatment was identified as an issue in 5 of the 8 wards visited by MHA Reviewers during Quarter 3.
Status:
It is requested that an extension be given to 31 March 2022 for this Must Do action plan to allow further improvements to be made.

Must Do Theme: (9) Environmental issues	**Lead:** **Paul McCabe, Director of Estates and Facilities & David Muir, Group Director**
Planned timescale for closure: 30 June 2021	
Long stay / rehab wards Year: 2015 Org: CPFT	The trust must ensure that the first floor of the building has clear lines of sight and an alarm call system that can be easily accessed to summon assistance.
Planned timescale for closure: 30 June 2022	
Adult acute wards Year: 2019 Org: CPFT	The provider must maintain premises in good condition and suitable for the purpose for which they are being used.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure that the health-based places of safety promote the privacy and dignity of patients in Carlisle and Whitehaven.

	The trust must ensure they take action in response to regulatory requirements and the findings of external bodies.
Planned timescale for closure: 30 July 2021	
OP wards Year: 2019 Org: CPFT	The provider must ensure that plans to relocate Oakwood ward are progressed and the use of dormitory style accommodation on Oakwood is either no longer used or a robust assessment and mitigation of risk is put in place.
Planned timescale for closure: 30 June 2021	
Community OP Year: 2017 Org: CPFT	The trust must ensure that all premises and equipment are safe and suitable for patients and staff. Premises must be reviewed in terms of access and reasonable adjustments to meet the needs of service users and staff. Medical equipment must fit for purpose and records kept to ensure it is well maintained.
Planned timescale for closure: 30 April 2021	
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that the environment at Edenwood is improved including the provision of specialist furniture which meet the needs of the patient using this service
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
Long stay / rehab wards	Nurse call system installations are well under way for Hadrian and Rowanwood wards and will be completed in April 2021. Edenwood is being used as a decant and so a Nurse Call system is not required at this point. Yewdale ward has a system fitted.
Adult acute wards	Work has been done in conjunction with the supplier of the anti-ligature door (Safehinge primera) as there was a concern regarding the bottom bracket. The issue has been resolved and a recommendation will be made on this product that it is suitable to install. The roll-out will be determined across the Trust on a prioritised basis (as determined by the Environmental Safety Group). Yewdale ward will be considered in the prioritisation.
MH crisis teams	Consideration being given to centralisation of 136 Suites into Carlton Clinic site. Various repairs have been done to suite in Whitehaven.
OP wards	The Oakwood scheme has started and is due for completion mid-June 2021.
Actions taken during Quarter 2 21/22 (July, August & September):	
Long stay / rehab wards	There is a different patient group utilising this ward since the original inspection was undertaken. There were two issues, line of sight and nurse call, the line of sight is mitigated by strategically placed mirrors and a nurse call system is in place.
Adult acute wards	Hadrian Business Case submitted to CDT-B and accepted. Estates and operational planning underway, work to begin in September 2021. Yewdale condition is being reviewed by estates in liaison with NCIC estates.
MH crisis teams	Plan was submitted to Clinical Environmental Safety Group. However, as work is above £25k then project should be support by a business case via CDT-B.
OP wards	The Oakwood scheme completed and patients returned to ward on 25 August 2021.

Actions taken during Quarter 3 21/22 (October, November & December):	
Adult acute wards MH crisis teams	<u>Hadrian</u> • Completion of enabling works • Ensuring staff numbers sufficient • Decant if above parameters met Mid October - Mid November Operational planning work has continued with further papers x2 being submitted to Executive Directors meeting and Business Delivery Group for approval of decant options. Decision made to support 2x 10 bed decants. Decision is that old Ruskin and Rowanwood will be used. Next stage of planning is agreeing the staff numbers against the proposed model. CERA assessment of old Ruskin has been complete and a further meeting is planned to review impact. <u>Yewdale</u> Work on Yewdale not progressing and there appears to be a range of outstanding areas to address. These are being followed up by Director of Estates and Facilities with NCIC colleagues.
MH crisis teams	Business case to be submitted fully, scheme of works devised with operational plan to support.
Planned actions to be undertaken during Quarter 4 21/22 (January, February & March:	
Adult acute wards MH crisis teams	<u>Hadrian</u> The refurbishment work has now commenced. Decant took place at the beginning of December and the ward has been separated in to 10 males located in the Rowanwood building and 8 females which remain in the existing Hadrian Ward. The work is scheduled to take approximately 10 months to complete <u>Yewdale</u> A scope of work has been agreed and finance allocated to complete the repair work on Yewdale. This will mainly consist of decorative work to all of the bedrooms, replacement, or repair of furniture and equipment as required and repair of the roof. The scope of work also includes work to be completed on the 136-suite based at Yewdale ward
Evidence of Impact:	
To further develop the evidence of impact.	
Status:	
Adult acute wards	Further action required to make improvements.
MH crisis teams	
OP wards	Closed by Board of Directors on 3 November 2021.
Community OP	Closed by Board of Directors on 26 May 2021.
LD & Autism wards	Closed by Board of Directors on 4 November 2020.
Long stay / rehab wards	Closed by Board of Directors on 4 August 2021.

Must Do Theme: (10) Risk assessment and record management	Lead: David Muir, Group Director & Elaine Fletcher, Group Nurse Director
Planned timescale for closure: 31 March 2022	
Community LD Year: 2015 Org: CPFT	The trust must ensure that staff complete and record patient's risk assessments consistently evidencing contemporaneous care records for patients who use services.
Community CYPS Year: 2017 Org: CPFT	The service must ensure that all young people receive a thorough risk assessment which is recorded appropriately in accordance with the trusts policies and procedures to ensure safe care and treatment.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established to maintain the records of each patient accurately, completely and contemporaneously.
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that risk assessments are regularly updated to reflect current risk and needs of patients.

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

- Update from the Risk Clinical Reference Group taken at BDG Safety February 2021. A further discussion to take place, but looking to support an 18 – 24 month project that would not just be able changing the risk tools, but also looking at culture.
- To continue to monitor compliance with the metrics below for improvement.
- FACE Risk Assessment Tool now live in North Cumbria the first metric below shows that this information is now pulling through and North Cumbria is now 91% compliant. There are no issues with compliance within any of the localities with regard to these metrics as at June 2021.
- Regular Audits of information continue to take place across the Trust, which monitors compliance with the issues raised.

Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):

- The transition of GRIST to FACE has now been completed and the project group was closed at the locality Quality Standards group held on 07/09/2021.
- During the project, both parts of the FACE training was implemented.
- All of the GRIST data has now been successfully migrated onto RiO and the testing of this is almost complete.

Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):

- Ongoing mandatory training will be monitored by the individual line managers.
- To ensure the FACE documents are being completed in a timely manner since the go live date, a process of monitoring is to be completed using data provided by the Commissioning and Quality Assurance team on a weekly basis. The Clinical Manager for Quality will be responsible for monitoring the completion rates of FACE documents along with data regarding risk assessments completed within a 12-month period. This will be shared with the Clinical Managers on a weekly basis.
- A compliance audit will be commenced in September 2021 with data being collated monthly. The purpose of this is audit is to review the completion of the FACE documents ensuring all the relevant sections have information within them. A tool has been produced for each of the different versions of the FACE document.
- A quality audit due to commence in November/December 2021.

Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):

Deferred quality audit due to commence in January 2022 to review the quality of the completed FACE documents however due to Opel 3 situation this may be delayed further.

Evidence of Impact:
CPA service users with a risk assessment undertaken/reviewed in the last 12 months at Quarter 3: • North Cumbria Locality – 90% (September), 91% (December) • North Locality – 98% (September), 98% (December) • Central Locality – 97% (September), 97% (December) • South Locality – 98% (September, 97% (December) Service users with identified risks who have at least a 12 monthly crisis and contingency plan at Quarter 3: • North Cumbria Locality – 89% (September), 88% (December) • North Locality – 95% (September), 95% (December) • Central Locality – 94% (September), 94% (December) • South Locality – 96% (September), 96% (December) Clinical risk and suicide prevention training standards at Quarter 3: • North Cumbria Locality – 70% (September), 71% (December) • North Locality – 85% (September), 85% (December) • Central Locality – 86% (September), 85% (December) • South Locality – 86% (September), 85% (December) One issue was identified (out of 8 MHA Reviewer visits) in relation to the completion of risk assessments during Quarter 3.
Status:
Continue to monitor rollout of transition from GRIST to FACE and awaiting results of audit.

Must Do Theme: (11) Staffing levels	**Lead: Anne Moore, Group Nurse Director**
Planned timescale for closure: 30 March 2022	
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that there are a sufficient number of appropriately skilled staff to enable the service to meet its target times for young people referred to the service.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure there is always a dedicated member of staff to observe patients in the health-based places of safety.
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.
Adult acute wards Year: 2019 Org: CPFT	The trust must deploy sufficient numbers of qualified, competent, skilled and experienced staff to meet the needs of patients care and treatment.
Actions taken Trust wide in Quarter 1 20/21 (April, May & June)	
Community CYPS	The North Cumbria Locality has medical vacancies within the CAMHS team, the locality has embedded new roles such as nurse prescribers to support the functioning of the team. The service can demonstrate minimal waits to treatment.
Adult acute wards	The North Cumbria Locality can demonstrate a robust approach to ward shift staffing and reporting of breaches. It is acknowledged there is a shortage of substantive staff for all shift, however the ward can evidence how these shifts are covered by a mix of overtime, bank and agency. The ward is able to clearly articulate how many breaches against it set staffing and can demonstrate ward to board reporting.

MH crisis teams	The North Cumbria Locality has provided evidence of the completion and implementation of a standard operating process of the staffing of the place of safety at Carlton Clinic and Yewdale. In addition, the night co-ordinator role has been implemented. There is evidence that the SOP has been agreed at CBU and Group level.
LD & Autism wards	The North Cumbria Locality has provided multiple sources of evidence regarding activities across all inpatient wards. There is evidence of events and timetables that are appropriate for the ward type/environment. There is evidence of patient facing information and displays of the events. There is evidence of continuous improvements at a team level via action planning.
Actions taken at core service in Quarter 1 20/21 (April, May & June)	
As per Trust-wide response.	
Actions taken Trust wide in Quarter 2 20/21 (July, August & September)	
Community CYPS Adult acute wards	• The North Cumbria Locality have adopted identical systems and processes for all CYP services including those linked to children learning disabilities and ADHD assessment service. The Locality now also monitors the wait to 3rd appointment, which gives additional insight into the CAMHS pathway waits. • The locality will continue with the Central Values Based Recruitment for both community and adult services and continue with ongoing recruitment. Currently reviewing the possibly of further nurse consultant appointments e.g. liaison and crisis. From a medical perspective we will be settling in our international medical recruits. • New Consultant Psychiatrist has been appointed to Rowanwood.
MH crisis teams	No further action required.
LD & Autism wards	No further action required.
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):	
During Quarter 2 the Trust experienced significant staffing pressures. These pressures are a result of unprecedented levels of staff absence (Covid staff sickness, Covid related self-isolations and non-Covid staff sickness), a high level of staff vacancies, increased patient acuity and bed pressures across the system. The Gold Command reconvened from mid-July 2021 and is closely monitoring these staffing pressures. A Trust-wide Recruitment and Retention Taskforce has been established to support and monitor the position. Actions include: • Deployment of Business Continuity Plans to maintain safe staffing. • Redeployment of staff based on clinical risk and pressures. Including inter-locality support. • Collaborative working with our partners across health and social care. • Crisis and ICTS teams proactively working into patients' homes and acute Trusts via liaison to keep people safe and support in the community. Avoiding the need for unnecessary admissions. • Non-essential activities have been stood down (training, corporate and external meetings). Recruitment and retention is currently the number one priority. • Focus on recruiting to vacant positions via central values-based recruitment. • Contacting retired staff with a view to returning. • Following recent national guidance on returning isolating staff to work with robust risk assessment and with approval from the DIPC. • Redeployment of corporate staff to support operational service delivery. • Adjustment of risk registers to reflect current position relating to staffing. • Daily operational monitoring through sitreps at Locality level.	

• Exploring the potential in relation to incentivising recruitment within the Trust. • Offering Bank staff substantive contracts. • Offering part-time staff additional hours. • Offering Retire and Return staff additional hours due to current pension rules. • Ensuring that all staff due to retire are offered the opportunity to return.
Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):
• The Trust-wide Recruitment and Retention Taskforce is currently meeting fortnightly for oversight of the ongoing actions, as detailed above in the Quarter 2 update. • As a result of the relaxation of Covid-19 travel restrictions, the Trust has re-established facilitating the transfer of international recruits (both Nurses and Doctors). • Updates on Recruitment and Retention Taskforce by way of a presentation taken to Council of Governors, Quality and Performance Committee and CQC colleagues during Quarter 3.
Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):
• Trust-wide Recruitment and Retention Taskforce to continue with actions listed within the Quarter 2 update above.
Evidence of Impact:
• CYPS waiting times. • Vacancy levels. • Safer Staffing reports.
Status:

Community CYPS	Action plans reopened in July 2021 as further action required to make improvements.
Adult acute wards	
MH crisis teams	
LD & Autism wards	

Must Do Theme: (12) Physical health and Rapid tranquilisation	**Lead: Anne Moore, Group Nurse Director and David Muir, Group Director**
Planned timescale for closure: 31 December 2021 (31 March 2022)	
Adult acute wards Year: 2018 Org: NTW	The trust must ensure that staff monitor the physical health of patients following the administration of rapid tranquilisation
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff monitor patients' physical health including, following rapid tranquilisation, in accordance with national guidance, best practice and trust policy.
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure they have effective systems and processes to assess, monitor and improve care and treatment. This includes identifying, individually assessing and reviewing, blanket restrictions, clear oversight of staff supervision and ensuring all physical health monitoring is completed as required. [This must do is also linked to blanket restrictions and staff supervision]
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff review patients' observations following the use of rapid tranquilisation to comply with the provider's rapid tranquilisation policy and National Institute of Health and Care Excellence guidance.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Confirmation given by IMG for audit work to resume (on-hold since January 2021 due to pandemic pressures). • Re-audit registered and underway using May data. • Audit results to be considered at next sub group meeting on 28/06/21.	

Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):
• The Clinical Audit results were reviewed by a small working group. There were some delays because of the return to restricted working with the return of Covid-19 over last couple of months. The Clinical Audit report gave limited assurance that physical health monitoring following intramuscular rapid tranquilisation medication is completed consistently across the Trust. The results indicated that improvements were still required in a number of areas. • Revisit training needs - policy states that the monitoring needs to be documented on NEWS2 / PEWS and RT monitoring chart. Last policy review it was only required to record electronically on RiO then NEWS2 chart was introduced but then direction came from Clinical Audit, IT and Safer Care that it was required to duplicate the information on the RT monitoring chart on RiO as this would inform Talk First dashboards, allowing wards to monitor. This is causing confusion. Also issues with temporary staff having the right permissions to be able to input information. Revisiting the training needs will be carried forward into Quarter 3.
Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):
• A working group with wider representation from all localities to take actions forward has been established and meets fortnightly. • Review of RiO / NEWS2 to see if recording can be simplified. • Anecdotal evidence that Oxehealth improves compliance. • Establish if reminders can be put into the RT form on EPMA. • CBUs to establish if what checks are being carried out by Nurse in Charge and supervision arrangements for rapid tranquilisation to be covered in this. • Agency access to RiO to be confirmed, has been raised to Gold Command – booked regular agency not an issue but is an issue for those booked last minute to cover. • Approve the audit/audit action plan for circulation/dissemination. • Rapid tranquillisation learning package and pull relevant sections into power point for delivering to HCA's on the wards who may be tasked with undertaking observations. • Audit approved by Clinical Effectiveness Committee following some queries. • Audit results cascaded via Business Delivery Group on 21 December 2021. Results still need to go to CQC Inspection Steering Group, Compliance Groups, Physical Health Care Group and Group Quality Standard meetings. • Further information approved to go into Trust Bulletin.
Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):
• Continue with above actions. • Re-audit being undertaken in January 2022.
Evidence of Impact:
Results of re-audit.
Status:
It is requested that an extension be given to 31 March 2022 for this Must Do action plan to enable further actions to be carried out and re-audit to take place.

Must Do Theme: (14) Staff engagement	Lead: Elaine Fletcher, Group Nurse Director
Planned timescale for closure: 30 June 2022	
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff working on Rowanwood feel supported, valued and respected following serious incidents beyond ward level.
Actions taken during Quarter 1 21/22 (April, May & June):	
• Facilitated feedback session to be arranged with the staff on Rowanwood to discuss the theming from the Stress Risk Assessment. • Further sessions will be arranged and will cover the following:	

– Introduction to the programme, vision, values and agreed team charter/compact. – Session for staff to identify areas of improvement and outline next steps. – Set up follow up sessions for improvement projects. – A date has been arranged for the relevant staff to meet in April to agree dates for the planned sessions.
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):
• Due to the delay since the initial introduction of this process 2 listening events are to be arranged, one of these took place in June and a further event is to be arranged during July 2021. The sessions have been structured and allow questions and answers. • Further focused development sessions will take place thereafter where the team will start setting the scene for the vision and values which will form part of the ward charter. • 2 half day sessions to be planned in September which will bring all the information together from the structured development sessions and will use these to complete the charter. On-going support will be offered from the innovations team.
Planned future actions to be taken Trust-wide during Quarter 3 21/22 (October, November & December):
Actions will be reviewed prior to re-opening of ward.
Evidence of Impact:
Baseline survey results.
Status:
This ward has now been closed on a temporary basis. Actions will be reviewed prior to re-opening of ward.

Must Do Theme: (17) Bed Management	**Lead: Andy Airey, Group Director**
Planned timescale for closure: 30 June 2022	
Adult acute wards Year: 2019 Org: CPFT	The trust must continue to look at ways of reducing out of area placements and the management of bed availability to ensure this meets the needs of people requiring the service.
Actions taken at core Service in Quarter 1 20/21 (April, May & June)	
As per Trust-wide response.	
Actions taken Trust wide in Quarter 1 20/21 (April, May & June)	
Implemented new process and policy which has led to positive feedback from North Cumbria CCG regarding the reduction in out of area placements as a result of the introduction of a new bed management function and policy.	
Planned future actions:	
• Introduction of an Inpatient Incident Management Group. • Review of community provision. • Review of Delayed Transfers of Care	
Evidence of Impact:	
The number of OAP days during Quarter 3 has increased from 141 to 555 (83 of which were appropriate). • Sunderland – 15 (Quarter 3) • Newcastle Gateshead – 87 (Quarter 3) • Northumberland – 119 (Quarter 3) • North Tyneside – 78 (Quarter 3) • North Cumbria – 256 (Quarter 3)	
Status:	
Action plan reopened across all core services in January 2022.	

Must Do Theme: (20) Management supervision	Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance
Planned timescale for closure: 31 December 2021 (31 March 2022)	
Community OP Year: 2017 Org: CPFT	The trust must ensure that all staff receive clinical and management supervision and that it is documented. The trust must ensure that supervision figures are shared appropriately with senior managers.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Trajectories in place across all groups and corporate services. • Managed actioned taken to achieve trajectories.	
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):	
Due to the impact of Covid-19 the Trust moved back to Opel Level 2 during this period and paused non mandatory activities including achieving standard for Management Supervision.	
Actions taken Trust-wide during Quarter 3 21/22 (October, November & December):	
On 1 October 2021 it is planned to reintroduce non mandatory activities including improving compliance with management supervision. Each management area has been asked to review their trajectories to achieve the 85% standard. These will be discussed at the Board in its October meeting. Following agreement of trajectories, we will reintroduce performance monitoring of agree trajectories.	
Planned future actions to be taken Trust-wide during Quarter 4 21/22 (January, February & March):	
Continue to monitor against agreed trajectories.	
Evidence of Impact:	
Current Position as of 31 December 2021 (Including improvement √ or deterioration from last quarter): 45%: √ Medical Directorate 36%: √ Deputy CEO Directorate 26%: Chief Nurse Directorate 26%: CEO Directorate 45%: √ North Cumbria Group 52%: √ North Group 48%: Central Group 65%: √ South Group 61%: √ Chief Operating Officer Directorate 82%: Commissioning & Quality Assurance Directorate Areas achieving full standard of 85%: 86%: Workforce Directorate 87%: Provider Collaborative Directorate 91% Mental Health Legislation	
Status:	
Process in place to record, focus now on delivering in line with trajectories.	

Must Do Theme: (2) Blanket restrictions	Lead: Karen Worton, Group Nurse Director
Planned timescale for closure: 30 September 2021	
Adult Acute wards Year: 2018 Org: NTW	The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.
Adult Acute wards Year: 2019 Org: CPFT	The trust must ensure that blanket restrictions are all reviewed and individually risk assessed.
Actions taken at core service level during Quarter 4 20/21 (January, February & March):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
• Policy ratification communicated via Trust Policy Bulletin. • A sample audit of restrictions with reason care plans was completed for Secure Care Learning Disabilities Services. Where in place there was evidence of personalisation with no blanket restrictions.	
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Blanket Restriction Registers to be held on Safer Care Intranet page. • Reintroduction of Peer Review process (maintaining IPC standards) when Covid-19 restrictions allow increased footfall across wards. • A snap shot review of Blanket Restriction Registers was completed for compliance with policy and CQC MHA Review Visit findings. • Monitoring of Blanket Restrictions and Restrictive Practice Incident Reporting ensures use of correct cause category BR01 or BR02.	
Actions taken Trust-wide during Quarter 2 21/22 (July, August & September):	
• A Blanket Restriction Register Dashboard is being created by Safer Care Team by end of July 2021. Wards will complete a monthly online submission form which will include the incident reporting number. • Peer Reviews have recommenced and will be completed by end of September 2021. The Peer Review schedule is now held centrally by the CQC Compliance Officer. • Agree standardised approach to Blanket Restriction Induction Training at a local level with CNTW Academy. • Policy to be refreshed to include introduction of dashboard reporting.	
Planned future actions to be taken Trust-wide during Quarter 3 21/22 (October, November & December):	
Project Team to continue to meet during Quarter 3 and 4 to progress with the above pieces of work.	
Evidence of Impact:	
Blanket restrictions were identified as an issue in 3 of the 8 wards visited by MHA Reviewers during Quarter 3.	
Status:	
Closed by Board of Directors on 3 November 2021.	

Must Do Theme: (6) Risk registers	Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues to make progress against the trust risk register and board members and members of staff understand the process of escalating risks to the board through the board assurance framework.
Crisis MH teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established and operating effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients.
Actions taken at core service level during Quarter 1 20/21 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 1 20/21 (April, May & June):	
Trust-wide	Following the CQC inspection there were identified weakness in the approach to risk escalation, risk management and assurance within CPFT. Following the transfer of services, the North Cumbria Locality adopts and implements fully the Risk Management Policy. Evidence that risk register is effectively reviewed and managed in line with the Trust Policy and that there is evidence of a clear link between the register and the Board Assurance Framework.
MH crisis teams	The North Cumbria Locality has provided evidence of adopting CNTW governance structures, evidence of actions, reports completed and sharing of information and cycle of meetings. The CNTW board reported provides evidence of communication processes from Ward to Board. There are standardised agendas in use in team meetings at Group level and these are replicated at CBU level.
Planned future actions:	
No further action required.	
Evidence of Impact:	
• Cycle of risk register review through CDT-R. • Review and update of Risk Management Strategy received by Board in November 2020. • Board Development session in February 2021 to review risks, identify any emerging risks to be added to BAF, review risk appetite categories and scoring. • Development of future Strategy proposed.	
Status:	
Closed by Board of Directors on 5 August 2020.	

Must Do Theme: (8) Collecting and acting on feedback from service users and carers	Lead: Allan Fairlamb, Head of Commissioning & Quality Assurance
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that quality monitoring takes place to measure service performance, outcomes and progress and ensure feedback from young people and their carers is incorporated into this.
Actions taken at core service level during Quarter 1 20/21 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 1 20/21 (April, May & June):	
The Access and Community CBU has provided evidence patient and carer involvement via a locality 'Together' meeting. The North Cumbria Locality is undertaking work to understand the involvement of carers 'Getting to Know You' process. There is evidence that practice has been mainstreamed within the North Cumbria Locality.	
Planned future actions:	
No further action required.	

Evidence of Impact:
Quarterly report to Board on patient feedback
Status:
Closed by Board of Directors on 5 August 2020.

Must Do Theme: (13) Governance	**Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance**
Planned timescale for closure: 30 September 2020	
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it reviews and improves its governance systems at a service level to ensure they effectively assess, monitor and improve care and treatment.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure that systems and processes are established and operating effectively to assess monitor and improve the quality and safety of services.
Actions taken at core service level during Quarter 1 20/21 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 1 20/21 (April, May & June):	
Trust-wide	Following the CQC inspection there were identified weakness in the approach to governance within the CPFT model. Following the transfer of services, the North Cumbria Locality adopts and implements fully the governance structures within CNTW.
MH crisis teams	North Cumbria Locality adopted the governance arrangements of CNTW from 1 October 2019.
Actions taken Trust-wide during Quarter 2 20/21 (July, August & September):	
Trust-wide	No further action required.
MH crisis teams	The North Cumbria Access and Community CBU can now demonstrate that Crisis teams have named representative at the CBU meetings. The CBU meeting follows a repeating pattern each month, the agenda cover operational, patient involvement, quality and service sustainability. These agenda have been imported from other localities and the meetings are support by the latest information from trust dashboards The CBU has provided the latest agendas as evidence.
Evidence of Impact:	
• Trust-wide governance structures. • Agreed terms of reference and policies in place.	
Status:	
Trust-wide	Closed by Board of Directors on 5 August 2020.
MH crisis teams	Closed by Board of Directors on 4 November 2020.

Must Do Theme: (15) Medicines Management	**Lead: Tim Donaldson, Chief Pharmacist/Controlled Drugs Accountable Officer**
Planned timescale for closure: 30 June 2021	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all medicines used are labelled and that risk assessments are always in place for the use of sodium valproate in female patients of child bearing age.
Actions taken at core service level during Quarter 4 20/21 (January, February & March):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	

All four locality CBUs have created valproate action plans on the back of presentation of interim POMH-UK data at BDG-Safety meeting 11 December 2020. Action plans continue to be monitored by BDG-Safety through to completion and include the following initiatives:

- Remaining 49% (n=118) of women and girls of childbearing age, as identified by pharmacy colleagues, are being reviewed for compliance with the valproate PPP
- North Cumbria locality have tasked a Nurse Consultant with undertaking all appointments and ensuring valproate PPP reviews are completed
- CCGs have been approached to provide contemporaneous lists of patients whom are prescribed valproate for a mental health indication to enable cross-referencing with SNOMED-CT report
- Local databases have been created and accessible on shared drives by Nurse Consultants
- A standard letter addressed to all specialist prescribers has been circulated setting out specific responsibilities with deadline for action of end February 2021
- Masterclass training sessions have been authored and arranged by pharmacy colleagues in association with CNTW Academy. Classes underway March 2021
- Creation of a RiO 'virtual team' has been considered to overcome metric methodology implications (open referrals) of eligible patients who have been discharged
- Amber shared care status of valproate in women and girls of childbearing age has been proposed at the NoT Formulary Subcommittee with Medicines Guidance and Use Group (MGUG) beginning work on this initiative. Proposal discussed at SoT Area Prescribing Committee
- Trust notified by NHSE&I National Director of Patient Safety that a recently established Valproate Safety Implementation Group (VSIG) will drive forward work to reduce harm from valproate
- PPT-PGN-25 Safe Prescribing of Valproate currently undergoing routine scheduled review by pharmacy; summary process flowchart to be incorporated to assist prescribers
- Development of a Valproate Documentation section on RiO (under Service Specific Files> Physical Treatment) which will include electronic versions of side effect rating scales and hyperlinks to the Valproate PPP material

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

- Presentation of BDG paper to MOC in Quarter 1 21/22.
  Local findings from additional questions added to POMH Topic 20a audit, presented to May 2021 MOC meeting
- Presentation of POMH Topic 20a Trust report to MOC once received from POMH in Quarter 1 2021/22.
  Completed May 21; presentation of findings to MOC and Valproate Oversight Group.
- Receipt of POMH-UK Topic 20a Trust report and interpretation of findings by pharmacy colleagues.
  Completed May 21; presentation of findings to MOC and Valproate Oversight Group.
- Complete review of remaining women and girls of childbearing age as identified in BDG-Safety paper December 2020.
  Completed June 21. All localities are reporting that WGOCP identified as eligible for PPP (from the original n=242 cases appearing in the BDG-S paper December 2020) have been identified and reviewed. Some areas still working to ensure that all those not eligible for PPP have documentation updated to reflect this.
- Contemporaneous CCG patient lists to be compared to SNOMED-CT report to establish if any patients have been overlooked.
  Update by locality:
  North – CCG lists requested and obtained from North Tyneside (none received from Northumberland); comparison to original n=242 cases identified within CNTW is underway.

Central – Newcastle/Gateshead CCGs approached for lists; CCGs completed their own review in April 2021 and are hesitant about providing further lists due to additional administrative burden. CCGs have confidence in existing process (quarterly review by Pharmicus) to ensure all WGOCP are re-referred back to CNTW as per requirements of valproate PPP.
South – Pharmicus carrying out similar work in Sunderland and South Tyneside
North Cumbria - 39 GP Practices approached for data; to date all but 7 practices have submitted a return. Escalated the non-returns within the local CCG. Lists currently being compared.
Action transferred to Valproate Oversight Group – suggest closure

- Further investigation of an IT solution to identify annual Valproate PPP review (for all patients including those open to referral only) and alert prescribers. Action likely to be affected by national Shared Care Protocol – patients not to be discharged in interim (Internal CAS alert CNTW/INT/2021/010).
  Action transferred to Valproate Oversight Group – suggest closure
- Locality SOPs to be drafted to detail process/roles/responsibilities going forward. PPT-PGN-25 currently being reviewed with process flowchart; SOPs unlikely to be needed.

Planned future actions:

None, remaining actions transferred to Valproate Oversight Group for oversight and embedding of standards contained within PPT-PGN-25.

Evidence of Impact:

- Raised awareness of prescribing standards contained within PPT-PGN-25. Presentation of interim POMH-UK findings at BDG-Safety in December 2020, resulting locality action plans and establishment of the Valproate Oversight Group (VOG) have all raised awareness of prescribing standards contained within PPT-PGN-25. Valproate Masterclasses undertaken by pharmacy colleagues have reached 172 staff as of 27 April 2021. Further regular six-monthly Masterclasses to be arranged to engage new medics joining the Trust (VOG action plan).
- Accurate completion of SNOMED-CT alert on RiO will create contemporaneous register of females of childbearing age who are receiving valproate within CNTW services.
  Quarterly SNOMED-CT reports continue to be produced and circulated to locality valproate leads for comparison against locally held patient lists. Business as usual.
- Compliance against PPT-PGN-25 standards will ensure annual risk assessment documentation is copied to the patient's GP and next appointment diarised.
  Q4 2021/22 Clinical Audit to be undertaken to review compliance against PPT-PGN-25 standards. Results to be fed back to MOC, VOG and BDG-S

Status:

Closed by Board of Directors on 4 August 2021.

Must Do Theme: (16) Nurse Call Systems	**Lead: Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: 30 June 2021	
Adult acute wards Year: 2018 Org: NTW	The trust must ensure patients have access to a nurse call system in the event of an emergency.
Actions taken at core service level during Quarter 3 20/21 (October, November & December	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 3 20/21 (October, November & December):	
Following discussion with the Locality Group Nurse Directors a phased implementation of the nurse call systems will take place over the coming year subject to priorities identified on the capital programme. At the November CDT-Business this approach was agreed.	

The provision of nurse call systems into facilities at North Cumbria (Hadrian, Edenwood, Rowanwood and Yewdale) and Gibside ward, St Nicholas Hospital, Newcastle was deemed to be the priority.
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):

• Installation of nurse call systems has been completed for the following wards:
  o Hadrian, Carlton Clinic
  o Rowanwood, Carlton Clinic
  o Yewdale Ward, West Cumberland Hospital
  o Gibside, St Nicholas Hospital
• Edenwood is currently being utilised as decant office accommodation. Prior to any inpatient occupancy a nurse call system will be fitted.

Actions taken Trust-wide during Quarter 1 21/22 (April, May & June)
• Installation of nurse call systems have been completed across all acute wards for adults of working age and PICU across the CNTW patch. • Further conversations between NTW Solutions and other clinical service areas will take place during Quarter 2 and 3 to agree priorities and next steps linked to the available capital budget for 2021/22.
Planned future actions:
No further action required.
Evidence of Impact:
Assurance of completion of work.
Status:
Closed by Board of Directors on 4 August 2021.

Must Do Theme: (18) Section 17 Leave	**Lead: Dr Patrick Keown, Group Medical Director**
Planned timescale for closure: 30 June 2021	
OP wards Year: 2019 Org: CPFT	The provider must ensure that all section 17 leave forms are individually completed for each patient and show consideration of patient need and risks.
Actions taken at core service level during Quarter 4 20/21 (January, February & March):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
• Audits have been evaluated and results showed that compliance was good or adequate in all cases. • The recommendations of the task and finish group following the findings from the data (i.e. compliance poor if falls on bank holiday or weekends) were shared by CBU representatives within their respective localities – to continue to monitor compliance with section 17 leave through the Mental Health Legislation Steering Group. • Small group met to discuss accompanied and escorted leave and to review the leave policy. The guidance was circulated by the CBU representatives. • Work remains on-going with RiO team to look at the possibility of setting up an alert system to assist with compliance.	
Actions take Trust-wide during Quarter 1 21/22 (April, May & June):	
• Monitoring of section 17 data continues as there has been a noted increase in non-compliance during holiday periods. • Share again the recommendation for expiry dates for section 17 leave forms to be mid-week days avoid weekends and Mondays; avoid end of the month; avoid settings forms to expire during annual leave; use day of the week when there is regular Responsible Clinician input; use at a glance board.	

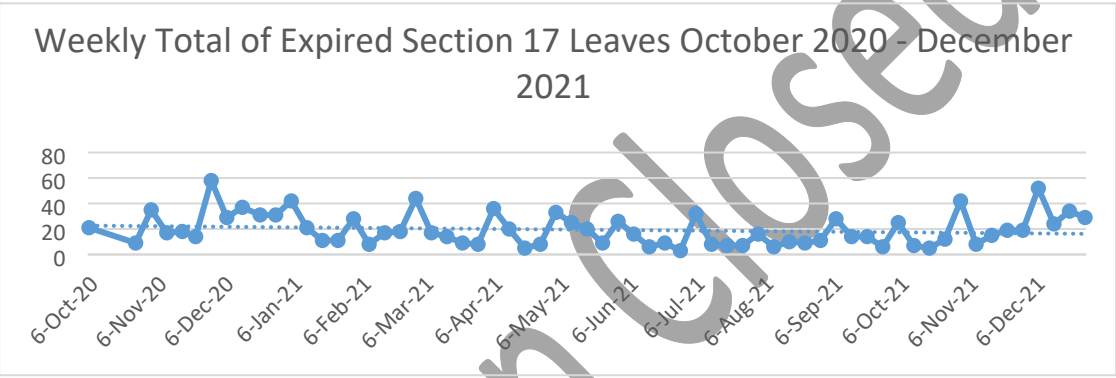
- Share again with Responsible Clinician's in each CBU the guidance produced on escorted and accompanied leave and the need for each patient to have an individualised section 17 leave form.

Planned future actions:

- Monitoring of section 17 data continues. This will be on-going through the Mental Health Legislation Group and the weekly reports which are sent out to all wards.
- Information was shared with relevant individuals as discussed in points 2 and 3 above.

Evidence of Impact:

Section 17 compliance data below. The graph shows that non-compliance with section 17 leave forms continued to decline throughout 2021 on a downward trend from an average of 30 per week to under 20 per week. There was a notable peak during December 2021 similar to December 2020.



No issues regarding Section 17 were identified from MHA Reviewer visits during Quarter 3.

Status:

Closed by Board of Directors on 4 August 2021.

Must Do Theme: (19) Clinical audits	**Lead: Dr Kedar Kale, Group Medical Director**
Planned timescale for closure: 31 December 2020	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that clinical audits are effective in identifying and addressing areas of improvement within the service.

Actions taken Trust-wide during Quarter 1 20/21 (April, May & June):

The North Cumbria locality can demonstrate it has embedded the Trust-wide approach to clinical audit and re-audit. The trust overall has a significant amount of evidence regarding a robust approach to clinical audit.

Actions taken at core service level during Quarter 1 20/21 (April, May & June):

As per Trust-wide response.

Actions taken Trust-wide during Quarter 2 20/21 (July, August & September):

The North Cumbria locality has significant evidence of audit, action plan and re audit. The Trust has significant evidence of audit process up to committee stage.

Actions taken during Quarter 3 20/21 (October, November & December):

- A tracker has been created which will allow the locality to manage the oversight of audit actions that are applicable to the locality. Tracker was discussed and agreed at North Locality Operational Management Group on 1 December 2020.
- The tracker will be maintained by the Nurse Manager for Quality who started on 14 December 2020.

Evidence of Impact:

- Locality and Trust-wide governance structures.
- Locality cycle of meetings.

• Locality tracker.
Status:
Closed by Board of Directors on 3 February 2021.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting on Wednesday 2 February 2022

Title of report	Board Assurance Framework (BAF) Corporate Risk Register (CRR) Exception Report
Report author(s)	Yvonne Newby, Risk Management Lead.
Executive Lead (if different from above)	Lisa Quinn, Executive Director of Commissioning and Quality Assurance

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

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	26 January 2022
Audit	26 January 2022
Mental Health Legislation	26 January 2022
Remuneration Committee	
Resource and Business Assurance	26 January 2022
Charitable Funds Committee	
CEDAR Programme Board	
Provider Collaborative Committee	15 December 2021

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

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
Mental Health Legislation Sub Committee **SA5** The Trust Will Be The Centre Of Excellence For Mental Health And Disability **Risk 1691** As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. SA5.
Board Assurance Framework/Corporate Risk Register risks this paper relates to
Quality and Performance Sub Committee **SA1** Working Together With Service Users And Carers We Will Provide Excellent Care. Supporting People on Their Personal Journey To Wellbeing. **Risk 1683** There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands. SA1.4 **SA5** The Trust Will Be The Centre Of Excellence For Mental Health And Disability. **Risk 1688** Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements. SA5 **SA5** The Trust Will Be The Centre Of Excellence For Mental Health And Disability. **Risk 1694** Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services. (SA5.9) **SA4** The Trust's Mental Health And Disability Services Will Be Sustainable And Deliver Real Value To The People Who Us Them. **Risk 1836** A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm. (SA4) **SA4** The Trust's Mental Health And Disability Services Will Be Sustainable And Deliver Real Value To The People Who Us Them. **Risk 1852** There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver Trust business. This will impact on the quality and safety of care for patients. (SA4)
Board Assurance Framework/Corporate Risk Register risks this paper relates to
Resource and Business Assurance Sub Committee **SA1** Working together with service users and carers we will provide excellent care Supporting people on their personal journey to wellbeing. **Risk 1680** If the Trust were to acquire service level and additional geographical areas this could have a detrimental impact on CNTW as an organisation. SA1.10 **SA4** The Trust's Mental Health and Disability Services will be sustainable and deliver real value to the people who use them. **Risk 1687**: That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our transformation programme. SA4.2 **SA1** Working together with service users and carers we will provide excellent care Supporting people on their personal journey to wellbeing. **Risk 1762** Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments. (SA1). **SA4** The Trust's Mental Health and Disability Services will be sustainable and deliver real value to the people who use them. **Risk 1853** The climate and ecological change is affecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change. (SA4)
Board Assurance Framework/Corporate Risk Register risks this paper relates to
Provider Collaborative Sub Committee **SA4** The Trust's Mental Health And disability Services Will Be Sustainable And deliver Real Value To The People Who Use Them.

Risk 1831 Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users SA4
SA3 Working With Partners There Will Be “No Health Without Mental Health” And Services Will Be “Joined Up”.
Risk 2041: Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services. SA3.2

Board Assurance Framework and Corporate Risk Register

Purpose

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

This paper provides:

- A summary of both the overall number and grade of risks contained in the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).
- A detailed description of the risks which have exceeded a Risk Appetite included on the BAF/CRR.
- A detailed description of any changes made to the BAF and CRR.
- A detailed description of any BAF/CRR reviewed and agreed risks to close.
- A copy of the Trusts Risk Appetite table is attached as **appendix 1.**
- A copy of the BAF/CRR is included as **appendix 2**.
- **Appendix 3** gives a summary of both the overall number and grade of risks held by each Locality Group, Corporate Directorate Risk Registers, Clinical Groups, Corporate Business Units and Executive Corporate Risk Registers on the Safeguard system as at end of December 2021 there have been no risks escalated within the quarter, action plans are in place to ensure these risks are managed effectively and all risk are held at the appropriate level.
- A copy of Internal Audit Plan 2021/2022 as **appendix 4**.
- A copy of Clinical Audit Plan 2021/2022 as **appendix 5.**

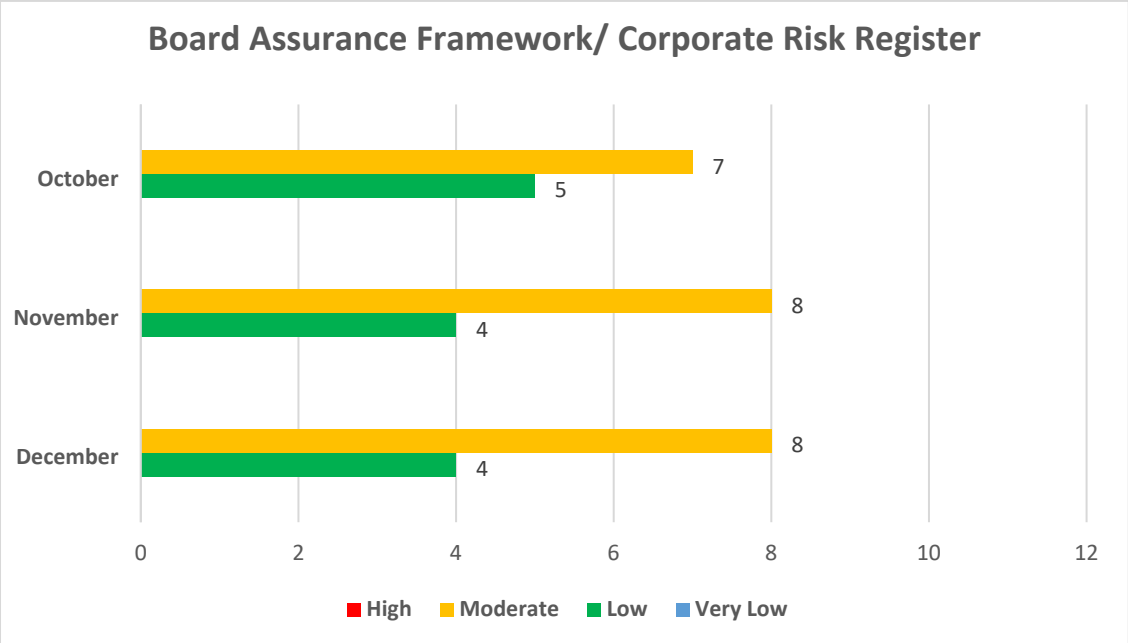
As mentioned in the Quarter 2 report there is still an increase in risks being reported in Appendix 3 of this report. This is due to Web Risk being implement at this level in line with our Risk Management Strategy. Training has been provided to support rolled out at Ward and Department level. A report has been created which informs the Risk Management Lead of any new risks which have been added to Web Risk Register within the last 7 days. This enables any quality issues to be identified and amended immediately. Six monthly Quality Risk Reports are being provided to each Locality to assist with quality issues with existing risks. The Group level/Corporate Risks that exceed the risk appetite will be reported in Appendix 3 as in previous reports. Any risk exceeding the risk appetite at CBU level (Community, Inpatient. Access and Specialist Services) will be recorded as follows: -

- Risk Numbers
- Appetite Category
- When Risks was last reviewed with CDT-R meeting
- When Risks will next be reviewed within CDT-R meeting

With the significant increase of risks now being recorded on the Web Risk System it would not be practicable to include them individually in this report. If any Board Member would like a detailed account of any risk listed in the report at CBU level or has any queries concerning a risk please do not hesitate to contact the Risk Management Lead.

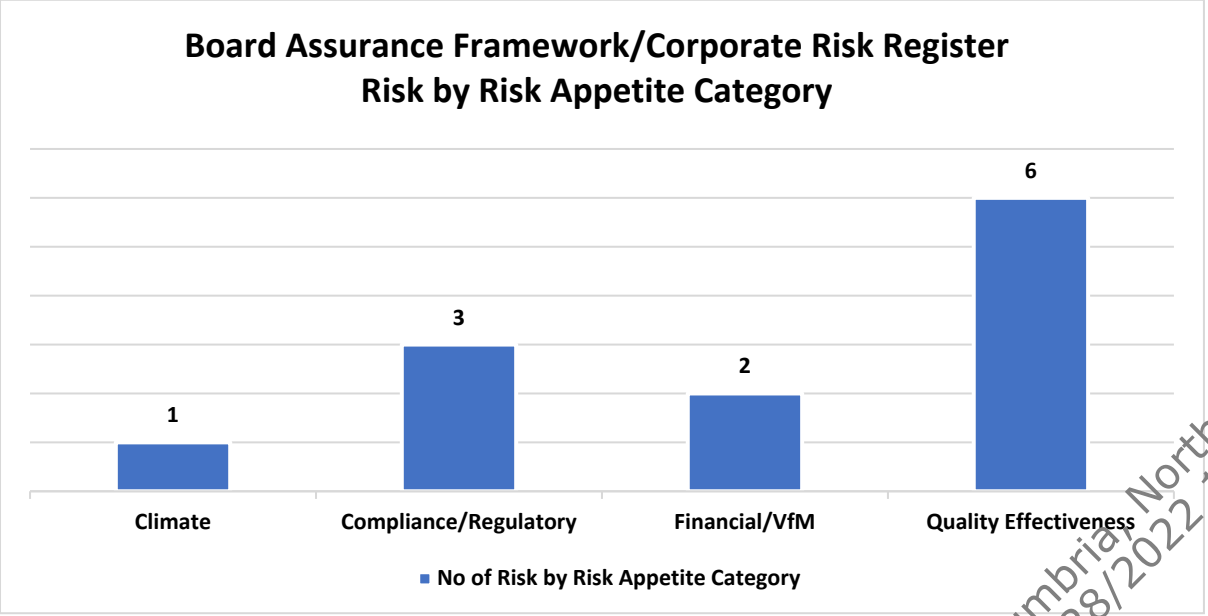
1.0 Board Assurance Framework and Corporate Risk Register

The below graph shows a summary of both the overall number and grade of risks held on the Board Assurance Framework/Corporate Risk Registers as at end of December 2021. In Quarter 3 there are 12 risks on the BAF/CRR.



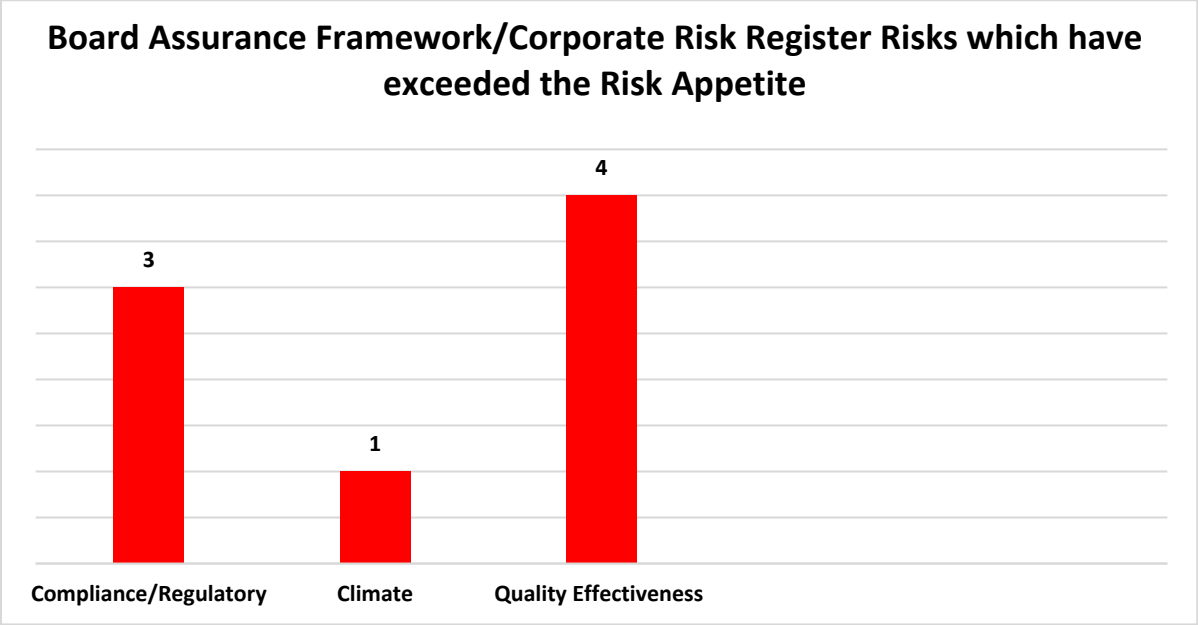
1.1. Risk Appetite

Risk appetite was implemented throughout the Board Assurance Framework/Corporate Risk Register in April 2017. The below table shows risks by risk appetite category. The highest risk appetite category is Quality Effectiveness (6) which is defined as risks that may compromise the delivery of outcomes.



Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 12 risks on the BAF/CRR and 7 risks which have exceeded a risk appetite tolerance.

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



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

Risk Reference	Risk Description	Risk Appetite	Risk Score	Executive Lead
1680v.44 SA1	If the Trust were to acquire service level and additional geographical areas this could have a detrimental impact on CNTW as an organisation.	Compliance/ Regulatory (6-10)	3x4 = 12	Lisa Quinn
1683v.22 SA1	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands.	Quality Effectiveness (6-10)	4x4 = 16	Ramona Duguid
1688v.40 SA5	Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's	Compliance/ Regulatory (6-10)	3x5 = 15	Lisa Quinn

	statutory duties and regulatory requirements.			
1691v.31 SA5	As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.	Compliance/ Regulator (6-10)	3x4 = 12	Rajesh Nadkarni
1694v.19 SA5	Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services.	Quality Effectiveness (6-10)	3x4 = 12	Ramona Duguid
1836v.12 SA4	A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm.	Quality Effectiveness	3x4 = 12	Ramona Duguid
1853v.12 SA4	The climate and ecological change is effecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change.	Climate & Ecological Sustainability	3x4 = 12	James Duncan
2041v.4 SA3	Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services.	Quality Effectiveness	3x4 = 12	Lisa Quinn

1.2. Amendments to BAF

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

Risk Ref	Risk description	Amendment	Executive Lead
1680 SA1	If the Trust were to acquire service level and additional geographical areas this could have a detrimental impact on CNTW as an organisation.	Risk description amended. Two new controls and assurances added. Action 6690 was discussed at CDT-B on 15.11.21 re developing Estates Strategy for the Trust completed and closed. Two new actions added.	Lisa Quinn
1683 SA1	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands.	One action updated and a new target date set.	Ramona Duguid
1687 SA4	That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our transformation programme.	All actions reviewed and new target dates set.	James Duncan
1688 SA5	Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements.	Both actions relating to Q2 have been closed and two new actions added for Q3. New control and assurance added. Residual scoring has increased to 15 due to access and patient pressure across the Trust and also pressures on training standards.	Lisa Quinn
1691 SA5	As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.	One control and assurance added. One Action, closed and moved to controls. Remaining actions updated and new target dates set.	Rajesh Nadkarni
1694 SA5	Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services.	Actions updated and new target dates set. One action has been closed	Ramona Duguid
1762 SA1	Restrictions in Capital expenditure imposed nationally may lead to increasing risk of	Actions updated and new target dates set.	James Duncan

	harm to patients when continuing to use sub optimal environments.		
1831 SA4	Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users	Two new actions added. One action updated and new target date set.	Lisa Quinn
1836 SA4	A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm.	All controls and assurances have been updated. One control was deleted from the risk. One action closed and 5 new actions were added with target dates set.	Ramona Duguid
1852 SA4	There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver Trust business. This will impact on the quality and safety of care for patients.	Three controls and assurances added. Action updated and new target date set.	Gary O'Hare
1853 SA5	The climate and ecological change is effecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change.	All actions updated and new target dates set.	James Duncan
2041 SA3	Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services.	One action has been closed. Two actions added with target dates set.	Lisa Quinn

1.3. Risk Escalations to the BAF/CRR

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

1.4. Risks to be de-escalated

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

1.5. Current BAF and Emerging Risks

Due to the Executive changes, the Board of Directors are asked to approve the following changes to Executive Leads from the 24th December 2021:

Risk Ref	Risk description	Executive Lead Change
1687 SA4	That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our transformation programme.	James Duncan to Lisa Quinn
1762 SA1	Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments.	James Duncan To Lisa Quinn
1853 SA5	The climate and ecological change is effecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change.	James Duncan To Lisa Quinn
1506	That there is a lack of investment in backlog maintenance of buildings, leading to health and safety risks and risks of non-compliance with regulatory requirements and not meeting essential accommodation standards	James Duncan To Lisa Quinn
1774	The Trust recognises the risks that fraud, bribery and corruption pose and have included this to ensure effective executive level monitoring is carried out.	James Duncan To Lisa Quinn

Due to the Chief Executive change, the Board of Directors are asked to approve the following change to Executive Lead from the 31st January 2022:

Risk Ref	Risk description	Executive Lead
1298	That we do not effectively engage public, commissioners and other key stakeholders leading to opposition or significant delay in implementing our service strategy.	John Lawlor to James Duncan

1.6. Recommendation

The Trust Board are asked to:

- Agree the changes to Executive Leads identified in 1.5.
- Note the changes and approve the BAF/CRR.
- Note the risks which have exceeded a risk appetite.
- Note the summary of risks in the Locality Care Groups/Corporate Directorate risk registers.
- Provide any comments of feedback.

Yvonne Newby
Risk Management Lead
10 January 2022

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

Risk Appetite Statement

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

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

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

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Appendix 2

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER 2021-2022 Quarter 3

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of governance	Improvement review of MHA Training: (Q1 21/22 - 64.6%) (Q2 21/22 - 64.1%) (Oct 2021 64.6%) (Nov 2021 64.8%) (Dec 2021 - 65.1%)
2 Trust Policies and Procedures relating to relevant acts and practice	2 Compliance with policy/training requirements NTW181957 Compliance review of MHA rights - Good Level - Feb 19	Awaiting the Government response to the consultation to then know what changes will take effect within the Mental Health Legislation
3 Decision making framework	3 Decision making framework document	
4 Performance review/integrated performance reports	4 Reports to Board and sub committees	
5 Mental health legislation committee	5 Minutes of mental health legislation committee	
6 New process in place for monitoring themes from MHA Reviewer visits through MHL Steering Group	6 MHL Group papers and updates	
7 CQC MHA Reviewer session delivered at learning and development group in November 2018	7 Minutes and papers from Learning and Development Group	
8 Internal Audit 18/19	8 NTW 2018/19/57 Compliance Review of MHA -	

			Patient Rights. Good. NTW 2018-19/58 Compliance Review of Mental Health Act - Rolling Programme - CTO - Substantial	
2	Effectiveness of reporting on themes from MHA Reviewer visits	2	Mental Health Legislation Steering Group. CQC compliance Group will now review themes and this will be carried out monthly.	
3	Regular review and monitoring of CQC themes raised with Groups at the Mental Health Steering Group and BDG	3	Mental Health Legislation Steering Group. CQC compliance Group will now review themes and this will be carried out monthly.	
4	Mental Health Act Reform Consultation ended on 21 April and CNTW submitted their response to the proposed changes on 20 April 2021 to the Government	4	The Government published the response to Reforming the MHA in July 2021. Currently no implementation date and most likely a few years off due to Covid.	
5	Working Task Sub Group to monitor remote assessments and support the digitalisation of the MHA -	5	Reported and monitored by IMG and BDG	
6	At a glance boards.	6	Report will be used to monitor compliance with consent to treatment provisions within part 4a of the MHA.	
7	Internal Audit CNTW 2021- 22/07 Performance Management report (SA5)	7	CNTW 2021- 22/07 Performance Management Report (SA5)	
8	Supreme Court ruling in the MM case in 2018. Ability to discharge detained patients (managed by LD Clinical Services)	8	The High Court decision made on 09.11.21. Provides a legal mechanism to enable capable restricted patients who need to be deprived of their liberty in the community, to live in the	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

	community on extended section 17 leave even if this means there is no element of hospital treatment.	

Ref: 1691v.31

Risk Owner: Rajesh Nadkarni

Next Review Date: 08/03/2022

Review/Comments:

08/12/2021 - Yvonne Newby
Reviewed today. One control added, Internal Audit report CNTW 2021- 22/07. Action 4323 Yvonne to contact Lorna to discuss this action- Action updated, closed and moved to controls. Action 5553 target date reviewed. Action 1155 updated with Training Dashboard figures.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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

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

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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

Ref: 1683v.22

Risk Owner: Ramona Duguid

Next Review Date: 29/03/2022

Review/Comments:

29/12/2021 - Ramona Duguid
Risk reviewed today. New target date for Action 6107. Patient Flow IMG established in December 2021 to standardise patient tracker meetings, DTOC meetings and approve the PGN for patients awaiting bed allocation. Additional patient flow/discharge resource also being scoped to support IP areas.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements. SA 5	Risk on identification (15/03/2018):	3	5	15	Moderate
	Residual Risk (with current controls in place):	3	5	15	Moderate
	Target Risk (after improved controls):	1	5	5	Very Low
SA5 The Trust will be the Centre of Excellence for Mental Health and Disability	**Risk Appetite (the amount of Risk NTW will accept)**	Compliance/Regulatory			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of Governance - amber/green rating	Quarter 3 update against the annual plan.
2 Trust policies and procedures	2 Compliance with policy and procedures	Quarterly Review of compliance against standards through accountability framework - Quarter 3
3 Compliance with NICE	3 Internal Audit - rolling programme	Action Identified in Clinical Audit CA-21-0010 Long-Term Segregation. Annual Audits to be carried out by Audit Nurse.
4 CQC Compliance Group and Compliance Steering Group - re-started fortnightly	4 Reports and updates to board sub committees	
5 Performance reviewed/integrated commissioning and assurance reports	5 Reports/updates to board sub committees	
6 Accountability Framework - Quarterly meetings	6 Accountability Framework document	
7 Regulatory framework of CQC NHSI	7 NTW18-19 - 19/05 CQC Internal Audit (well-led) - Process Substantial Assurance	
8 Agreement of Quality Priorities	8 Monitored via reports/updates	

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

1 NTW Internal Audit 20-21	1 Risk Based Audit of Performance Management & Reporting	
2 Monitoring of MHA Reviewer Visit actions and themes	2 MHA Reviewer Visit Database	
3 Clinical Audit Report - CA-21-0010 Long-Term Segregation 2020-2021.	3 Clinical Audit final report - 10.09.21	

Ref: 1688v.39

Risk Owner: Lisa Quinn

Next Review Date: 05/01/2022

Review/Comments:

01/12/2021 - Lisa Quinn
Reviewed today. Residual scoring has increased to 15 due to access and patient pressures across the Trust and also pressures on training standards.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services. (SA5.9)	Risk on identification (06/11/2018):	4	4	16	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
SA5 The Trust will be the centre of excellence for Mental Health and Disability	**Risk Appetite (the amount of Risk NTW will accept)**	Quality	Effectiveness		Breach

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

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 1694 v.19

Risk Owner: Ramona Duguid

Next Review Date: 29/03/2022

Review/Comments:

29/12/2021 - Ramona Duguid
Risk reviewed today. No changes to Actions - 2860 and 2859 new target dates set. Action 1224 has now been closed. Action 2243 and 6092 have been updated and new target dates set.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm. (SA4)	Risk on identification (01/06/2020):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	1	4	4	Very Low
SA4 The Trust's Mental Health and Disability services will be sustainable and deliver real value to the people who use them	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Trust oversight meeting in place to support mental health community transformation in line with NHS LTP.	1 Investment plans in place and agreed across local systems.	Ability to balance recruitment to new roles whilst not destabilising core services.
2 Locality leadership meetings with system partners established across place.	2 Increase in additional roles across PCNs and regular reporting into BDG on governance framework for new roles.	Maturity of PCN and secondary care relationships.
3 PCN recruitment and additional roles in progress.	3 Report on access and waiting times challenges to BDG.	Increase in demand and impact of COVID variant on transformation pace as well as general access and waiting times.
4 Waiting times for community access reviewed monthly with focus on long waiters and challenged pathways in place.	4 Commissioning and QA report to Q&P.	Model of care across each PCN will require some standardisation/core principles from a CNTW/secondary care perspective.
		Ability to engage with other parts of the system to achieve LTP goals

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 1836v.12

Risk Owner: Ramona Duguid

Next Review Date: 29/03/2022

Review/Comments:

31/12/2021 - Ramona Duguid
Risk reviewed today. All controls and assurances have been updated. One control was deleted from the risk. Action 4265 was closed and 5 new actions were added.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver Trust business. This will impact on the quality and safety of care for patients. (SA4)	Risk on identification (21/09/2020):	3	4	12	Moderate
	Residual Risk (with current controls in place):	2	4	8	Low (Yellow)
	Target Risk (after improved controls):	1	4	4	Very Low
SA4 The Trust's Mental Health and Disability services will be sustainable and deliver real value to the people who use them	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 IPC Board Assurance Framework	1 Infection Prevention and Control (IPC) Board Assurance Framework Board of Directors Meeting	Preparations are in place to work with COVID
2 Gold Command	2 Operational Services	
3 Measures in place for Emergency Opel Planning - Workforce and Services	3 Open and Closed Trust Board Monthly Reporting	
4 Vaccination roll out	4 Open and Closed Trust Board Monthly Reporting	
5 COVID 19 IMG's will now flex between daily and twice weekly.	5 Notes of meetings	
6 Booster vaccination rollout.	6 Open and Closed Trust Board Monthly Reporting	

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

1 Weekly briefing COVID report to Executive team and BDG.	1 Minutes from meeting.	

Ref: 1852 v.8

Risk Owner: Gary O'Hare

Next Review Date: 31/03/2022

Review/Comments:

15/12/2021 - Yvonne Newby
Risk Reviewed today - 3 Controls added, Action 6488 updated and new target date set.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Joint Programme Board	1 Minutes of meetings	Achievement of North Cumbria CQC must do improvement areas
2 Due Diligence	2 Due Diligence report	Agree Estates Strategy for North Cumbria
3 Exec Leadership	3 Identified Exec Lead	Review CQC improvement requirements through Board on a Quarterly basis Q3 due 2nd February 2022.
4 Specific Capacity Identified	4 Identified CNTW Team	Lead Provider Contract for Sunderland IAPT Service needs to be agreed.
5 Clear Oversight by Trust Board	5 Board Development sessions and Papers	
6 Secured workforce to deliver services	6 Identified staff	
7 Implementation plan developed	7 Implementation planning paper	
8 Contract agreed and completed	8 Contract report- Reviewed RBAC	
9 Monthly Implementation Group Chaired by Gary O'Hare	9 Minutes and reports from meeting	
Maintain oversight during the establishment of Lotus Ward	Closed Trust Board	

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

1 North Cumbria 2 years on Presentation, presented to Council of Governors 25.11.21	1 Copy of presentation	
2 Pressures on Systems across the whole organisation presentation to the Board 23.11.21	2 Copy of presentation.	

Ref: 1680v.43

Risk Owner: Lisa Quinn

Next Review Date: 05/01/2022

Review/Comments:

01/12/2021 - Lisa Quinn
Reviewed today. Two new controls added and assurances attached. Action 6690 has been completed and closed.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated governance framework	1 Annual Governance Statement, Quality Account ,Annual plans	Long term financial strategy to be presented to the Board March 22
2 Annual Financial Plan 21/22	2 Annual Financial Plan 21/22 submitted	Trust working in interim financial regime through COVID-long term implications to be assessed within long term strategy
3 Financial and Operating procedures	3 Policy/PGN NTW1718 26 Payroll expenditure ,NTW 1718 39 Cashier	
4 Quality Goals and Quality Account	4 External audit of Quality Account	
5 Accountability Framework	5 Accountability Framework Reports	
6 Quarterly review of financial delivery	6 Quarterly review delivered at RBAC	
7 Programme agreed for capacity to care and Trust Innovations capacity expanded	7 Capacity to care programme, report to BDG and CDT-B	
8 Going Concern Report	8 Going Concern Report - Audit Committee April 2019	

Risk Report

1 NTW 18/19 Internal Audit	1 NTW 1819 25 Single Oversight Framework, Substantial, April 2019 NTW 1819 37 Procurement: Good, July 2019 NTW 1819 38 Compliance Review of Key Financial Systems: Good, May 2019 NTW 18/19 43 Risk based audit of charitable funds - Substantial, August 2018 NTW18/19 41 Risk based audit payroll - Substantial, November 2018 NTW18/19 40 Central arrangements managing patient monies - Substantial, February 2019	
2 Quarterly Reporting of operational plan to CDT for August 2021 onwards	2 CDT papers re quarterly reporting	

Ref: 1687v.28

Risk Owner: James Duncan

Next Review Date: 31/03/2022

Review/Comments:

15/12/2021 - Yvonne Newby
Risk Reviewed today. All three action target dates have been updated.

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

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

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

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

1 ICS support nationally and funding identified	1 ICS bid document	
2 Asset sales now identified	2 Standard reporting at CDT-B and RBAC	
3 CEDAR Business Case FBC - bridging loan agreed	3 CEDAR Business Case	
4 Capital Plan for 21/22 agreed by the Board as part of the Annual Financial Plan	4 Board papers and Capital Plan	

Ref: 1762v.13

Risk Owner: James Duncan

Next Review Date: 31/03/2022

Review/Comments:

12/10/2021 - James Duncan
Reviewed today Action 5552 target date updated.

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Commitment of CNTW - Declared Climate Emergency	1 CNTW Climate Health Programme	Routine reporting of carbon intensive activity, sustainable transport measures and single use plastic is underdeveloped.
2 Plan to reduce carbon omission to net zero by 2040. Opportunities for decarbonisation funding actively sought.	2 Minutes of CDT-C	Develop a training resource to incorporate climate, ecological and social business into a business case
3 CDT-Climate meeting - monthly	3 CDT-D Minutes of meetings	Progressing a staff engagement programme.
4 The Board approved Green Plan has annual objectives which are monitored via CDT-C and RBAC.	4 CDT-C minutes	

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 1853v.12

Risk Owner: James Duncan

Next Review Date: 31/03/2022

Review/Comments:

15/12/2021 - Yvonne Newby
Risk Reviewed today. All three action target dates have been updated.

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users SA4	Risk on identification (01/06/2020):	4	3	12	Moderate
	Residual Risk (with current controls in place):	3	3	9	Low (Yellow)
	Target Risk (after improved controls):	1	3	3	Very Low
SA4 The Trust's Mental Health and Disability Services will be sustainable and deliver real value to the people who use them	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Sign Subcontracts	1 To complete	Monitor contracts for all sub-contracts for lead provider models
2 Clear Service Specifications	2 To complete	Lead Provider Contract for Sunderland IAPT Service needs to be agreed.
3 Contract monitoring meetings	3 Minutes of Contract monitoring meetings	Internal Audit to take place re Provider Collaborative Governance.
4 Governance Arrangement through to Board - New Sub Committee of the Board established to monitor Lead Provider Collaborative.	4 Board approved Governance arrangements	
5 Internal Audit NTW1718/22	5 Risk Based Audit of Commissioning Income Contracts and Monitoring Arrangements 16 January 2018	
6 Provider Collaborative Lead Provider Committee	6 Provider Collaborative Reporting	

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 1831v.17

Risk Owner: Lisa Quinn

Next Review Date: 05/01/2022

Review/Comments:

01/12/2021 - Lisa Quinn
Reviewed today one new action 7083 added.

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services. SA3.2	Risk on identification (21/09/2021):	4	4	16	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
SA3 Working With Partners There Will B "No Health Without Mental Health" And Services Will Be "Joined Up".	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Executive and Group leadership embedded at place.	1 Part of Place Based Leadership Models influencing models of care.	Develop a PC for MHLDA across ICS footprint.
2 Leadership of ICS MH Workstream.	2 Regular updates to Execs, CDT and Board	Look to increase LP models across Trust footprint.
3 Membership of other ICS workstreams (LD, Acute pathways).	3 Regular updates to Execs, CDT and Board	Meeting to discuss conducting an audit on Provider Collaboratives.
4 Partnership in place across ICS for MHLDA Specialised Services.	4 PB Papers and PC Committee oversight	Lead Provider Contract for Sunderland IAPT Service needs to be agreed.
5 Lead Provider Models for pathways e.g. CYPS, IAPT, Veterans, Substance Misuse.	5 PB Papers and PC Committee oversight.	

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 2041 v.3

Risk Owner: Lisa Quinn

Next Review Date: 05/01/2022

Review/Comments:

01/12/2021 - Lisa Quinn
Reviewed today. Action 6910 updated and new target date set.

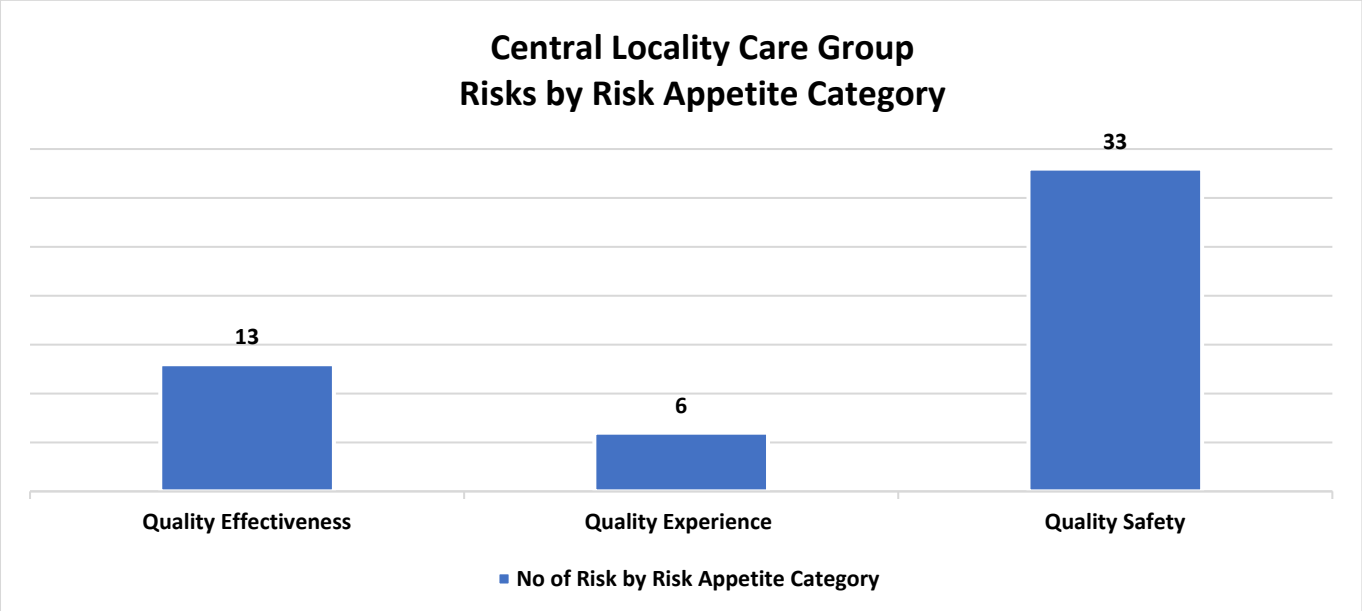
Appendix 3

Clinical Locality Care Groups and Executive Corporate Trust Risk Registers.

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

Clinical Groups

1.0 Central Locality Care Group



In total as at end of December 2021 Central Locality Care Group hold 52 risks, 42 risks have exceeded the risk appetite, 9 are within the appetite and 2 are below. All risks are being managed within the Central Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 9 risks on the Central Corporate Group risk register. Below are the 9 risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1038v.24	Medication information not accurately recorded at discharge and discharge summaries not issued in a timely manner. There is a potential risk of harm to service users if medication information is incorrectly communicated to GPs or the receipt of that information is delayed.	Quality Safety (6-10)	12	4	3	Karen Worton

1284v.30	Following an internal audit there is a risk around the monitoring arrangements for lone working which could result in reduced compliance and staff safety issues.	Quality Safety (6-10)	15	5	3	Karen Worton
1513v.23	Access and Waiting times within the ADHD and ASD Service The service is commissioned as an Adult Neuro-disability service and provides an autism diagnosis service and ADHD diagnosis and treatment monitoring service across the six trust localities. Agreed service specification is not available and the baseline for expected demand at the time of commissioning is therefore unclear. Weekly activity reports are provided for both ADHD and ASD services. The weekly activity reports indicate that there has been no significant improvement in flow and the waiting lists are not reducing. Discussions regarding capacity and demand have taken place with commissioners, however, no further investment has been confirmed to date. This poses a potential impact on service delivery and the effectiveness of treatment.	Quality Effectiveness (6-10)	15	3	5	Karen Worton
1665v.16	Staffing pressures due to vacancies and difficulties recruiting and retaining medical staff within the Central Locality Care Group. This poses a potential impact on service delivery and the effectiveness of treatment.	Quality Effectiveness (6-10)	16	4	4	Karen Worton
1737v.14	Access and Waiting Times within CYPS Community Services - Significant work has been undertaken with regard to waiting times within this service however there remains a significant issue in regards to waiting times. There is a risk to service delivery and the effectiveness of treatment delivered to our service users.	Quality Effectiveness (6-10)	16	4	4	Karen Worton
1763v.15	Current staffing pressures within the Secure Care service	Quality Safety (6-10)	15	5	3	Karen Worton

	currently being experienced due to each of the secure care learning disability wards having at least 1 complex patient who requires the support of additional staff resource. This poses a potential impact in the effectiveness of treatment and the safety of patients, staff and visitors					
1830v.8	Numerous incidents of environmental damage have occurred within the seclusion suites in the Secure Care CBU. The environmental damage impacts on the locking mechanism as well as the fabric of the seclusion room. There is a potential risk to patient safety if staff cannot enter the seclusion room and also a potential risk of escape and injury if staff cannot safely exit seclusion and lock the door behind them.	Quality Safety (6-10)	12	4	3	Karen Worton
2050v.5	There has been a significant increase in referrals for the ADHD service from all the six trust localities. There are currently over 4000 patients open to the ADHD team. The teams are underfunded, to manage the increase in demand. Clinicians are now struggling to manage the high volume of patients, and provide a Lead professional role, in all areas of the pathway. This includes providing a Duty system that can respond to all patients on the waiting list and in the Monitoring pathway. This includes managing general enquires, crisis support, signposting, Safeguarding and general mental health/ welfare advice. No discharge pathway out of CNTW.	Quality Effectiveness (6-10)	15	5	3	Anna Williams
2072v.3	A programme of refurbishment at Benton House indicates a full shut down of the building in February 2022. The closure is expected to last for one month. Benton House is the registered location for CTLD and CYPS services for the	Quality Effectiveness (6-10)	12	4	3	Karen Worton

	Community Central CBU and as such there is a risk that there will be a potential impact on service delivery (Quality Effectiveness) and service user experience (Quality Experience). Until the decant arrangements are known and actioned, there could be a significant effect on service delivery/ uncertain delivery of key objectives greater than 1 week.					

1.2 Central Locality Corporate Business Units

The four CBU's within the Central Locality currently hold a total of 43 risks. 34 of those risks have exceeded a risk appetite. The risks in this locality were last reviewed in the CDT-R meeting held on the 26th October 2020. These risks will be reviewed again at the CDT-R meeting to be held on the 21st February 2022. . (Please note CDT-R meetings were stood down for a time in 2021. Six monthly Quality Risk Reports are being provided by the Risk Management Lead to each Locality to assist with quality issues with existing risks in the absence of this meeting).

1.3 Community Central CBU

There are 19 risks for Community Central CB. There are 7 risks within the risk appetite. 12 risks have exceeded a risk appetite an no risks are below. The Appetite Categories for the 12 risks exceeding the appetite are 7 within Quality Safety, 4 within Quality Effectiveness and 1 within Quality Experience.

1.4 Inpatient Central CBU

Inpatient Central CBU has 19 risk. There is no or below risk within the risk appetite. 19 risks have exceeded a risk appetite. The Appetite Categories for the 19 risks exceeding the appetite are 16 within Quality Safety, 1 within Quality Effectiveness and 2 within Quality Experience.

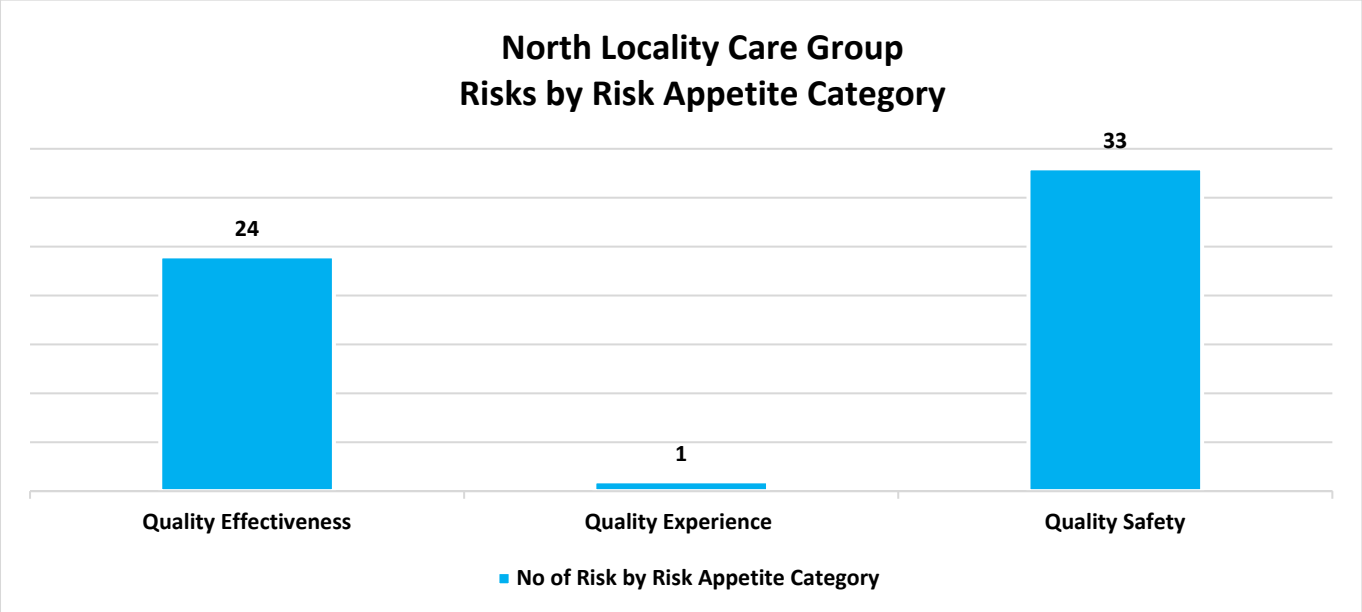
1.5 Secure Care Services CBU

There are 6 risks for Secure Care Services CBU. 1 risk is within the risk appetite there are no risks below the appetite. 5 risks have exceeded a risk appetite. The Appetite Categories for the 5 risks exceeding the appetite are 4 within Quality Safety and 1 in Quality Effectiveness.

1.6 Access Central CBU

Access Central CBU currently holds 1 risk. This risk exceeded the risk appetite. The Appetite Category for the 1 risk exceeding the appetite is within Quality Experience.

2.0 North Locality Care Group



North Locality Care Group as at end of December 2021 hold 58 risks, 28 risks within the risk appetite, 4 below the appetite and 26 risks which have exceeded the risk appetite. All risks are being managed within the North Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 6 risks on the North Corporate Group risk register. 1 risk is within the risk appetite and 5 risks are exceeding the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1176v.72	Significant staffing pressures due to vacancies and difficulties recruiting and retaining permanent medical, qualified nursing, SALT staff within the North Locality.	Quality Effectiveness (6-10)	20	4	5	Kedar Kale
1198v.50	Sickness absence levels continue to be monitored formally through the Locality LMG.	Quality Effectiveness (6-10)	12	4	3	Chloe Mann
1287v.38	Medication pages on RiO are not being kept up to date as per NTW Policy. Information transferred to the MHDS may not be accurate	Quality Safety (6-10)	16	4	4	Kedar Kale
1809v.20	CCTV coverage within St Georges Park site is extremely limited, the system is over 15years old and of poor quality. The wards only have coverage at the door entry system and does not cover reception and	Quality Safety (6-10)	16	4	3	Pam Travers

	admin areas. The lack of/poor provision makes SGP an outlier within the Trust in terms of security and compromised patient safety.					
1910v.7	Risk of harm to patients and members of the public due to the public toilet near the reception at St Georges Park not being anti ligature.	Quality Safety (6-10)	12	4	3	Pam Travers

2.1 North Locality Corporate Business Units

The four CBU's within the North Locality currently hold a total of 52 risks. 26 of those risks have exceeded a risk appetite. The risks in this locality were last reviewed in the CDT-R meeting held on the 28th September 2020. These risks will be reviewed again at the CDT-R meeting to be held on the 24th January 2022. (Please note CDT-R meetings were stood down for a time in 2021. Six monthly Quality Risk Reports are being provided by the Risk Management Lead to each Locality to assist with quality issues with existing risks in the absence of this meeting).

2.2 Community North CBU

Community North CBU is currently holding 17 risks. 7 risks are within the risk appetite and 10 risks are exceeding risk appetite no risks are below the appetite. The Appetite Categories for the 10 risks exceeding the appetite are 5 within Quality Safety and 5 within Quality Effectiveness.

2.3 Inpatient North CBU

Inpatient North CBU is currently holding 18 risks. 11 risks are within risk appetite. 5 risks are exceeding risk appetite and 2 risks are below the appetite. The Appetite Categories for the 5 risks exceeding the appetite are all within Quality Safety.

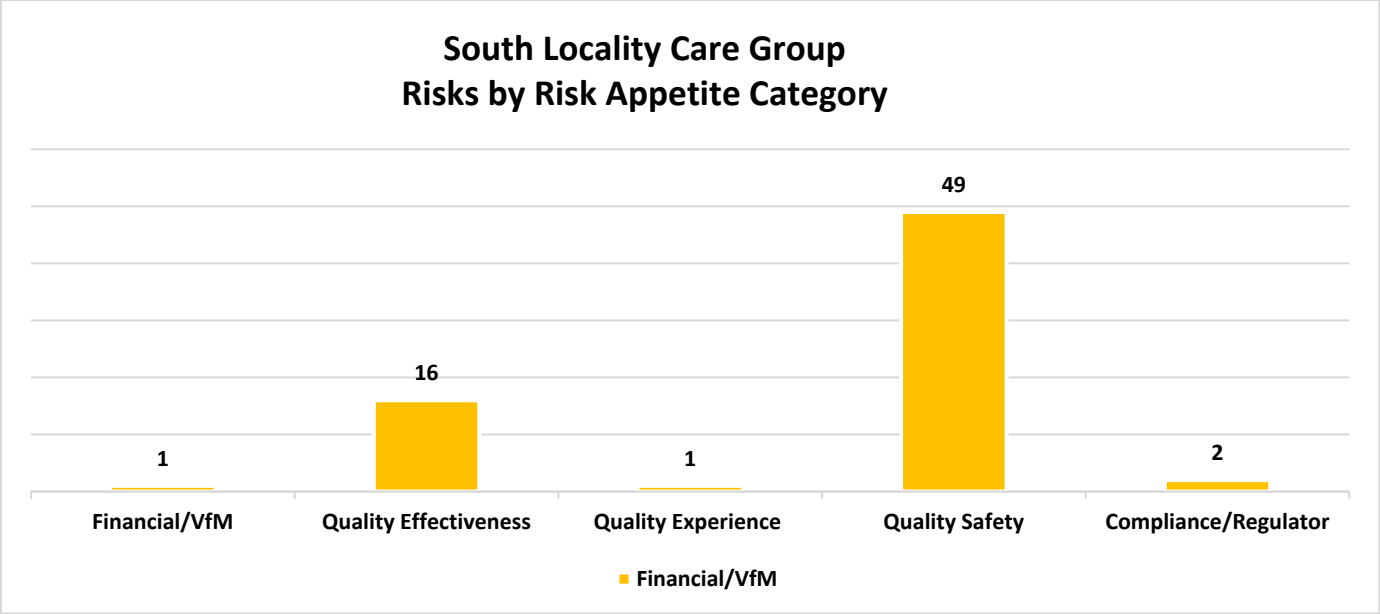
2.4 Access North CBU

Access North CBU is currently holding 3 risks – 1 risk is within risk appetite and 1 risks are exceeding risk appetite and 1 risk is below the appetite. The Appetite Categories for the risk exceeding the appetite is within Quality Safety

2.4 Learning Disabilities & Autism CBU

Learning Disabilities & Autism CBU is currently holding 14 risks. 8 risks are within the risk appetite. 5 risks are exceeding risk appetite and 1 is below the risk appetite. The Appetite Categories for the 5 risks exceeding the appetite are 2 within Quality Safety, 3 within Quality Effectiveness.

3.0 South Locality Care Group



In total as at end of December 2021 the South Locality Care Group hold 69 risks, 2 risks are lower than the risk appetite, 29 risks within the risk appetite and 38 risks which have exceeded the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 6 risks on the South Corporate Group risk register – 6 risks have exceeded the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
857v.32	Due to the Internal en-suite doors it has been identified that there is a potential ligature risk following incidents across the Group and this could cause harm to our patients.	Quality Safety (6-10)	16	4	4	Andy Airey
1160v.25	There are pressures on staffing due to vacancies particularly Community CBU and RGN's at Walkergate Park which may impact on the quality of service, patient safety and experience.	Quality Effectiveness (6-10)	12	4	3	Andy Airey
1279v.25	Sickness absence levels are currently above the trust standard therefore there is a risk to the impact and quality of care that is delivered to our service users.	Quality Safety (6-10)	12	4	3	Andy Airey
1288v.38	Medication page's on RiO are not being kept up to date as per CNTW policy. Information	Quality Safety (6-10)	12	4	3	Andy Airey

	transferred to the MHDS may not be accurate.					
1497.v24	Staffing pressures due to vacancies and difficulties recruiting and retaining medical staff within the South Locality Group. Whilst recruitment has improved, there are ongoing pressures due to remote working during COVID and the impact of the Devon ruling regarding MHA assessments.	Quality Experience (6-10)	12	4	3	Patrick Keown
1769v.15	Lack of formal commissioned pathways for inpatient detox into the Acute Trusts resulting in delays to patient care and potential deterioration in health	Quality Safety (6-10)	12	3	4	Andy Airey

3.1 South Locality Corporate Business Units

The four CBU's within the South Locality currently hold a total of 63 risks. 32 of those risks have exceeded a risk appetite. The risks in this locality were last reviewed in the CDT-R meeting held on the 22nd November 2021. These risks will be reviewed again at the CDT-R meeting to be held on the 22nd May 2022. (Please note CDT-R meetings were stood down for a time in 2021. Six monthly Quality Risk Reports are being provided by the Risk Management Lead to each Locality to assist with quality issues with existing risks in the absence of this meeting).

3.2 Community South CBU

Community South CBU is currently holding 11 risks. 3 risks within the risk appetite and 8 risks which has exceeded the risk appetite. The Appetite Categories for the 8 risks exceeding the appetite are 1 within Quality Effectiveness and 7 are within Quality Safety.

3.3 Inpatient South CBU

Inpatient South CBU is currently holding 30 risks. 16 risks are within the risk appetite 1 risk is below the risk appetite. 13 risks are exceeding the risk appetite. The Appetite Categories for the 13 risks exceeding the appetite are12 within Quality Safety, 1 within Quality Effectiveness.

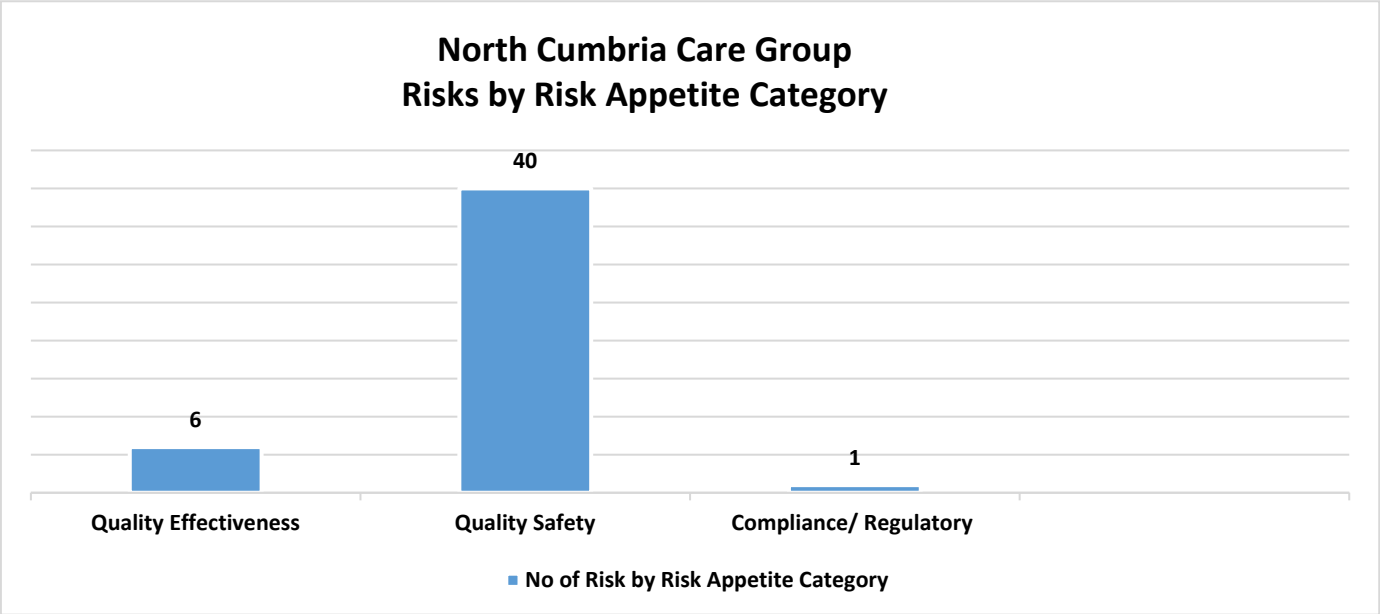
3.4 Neurological and Specialist Services CBU

Neurological and Specialist Services CBU is currently holding 21 risks, 1 risk is below the risk appetite, 10 risks are within the risk appetite and 10 risks are exceeding the risk appetite. The Appetite Categories for the 10 risks exceeding the appetite are 7 within Quality Safety and 3 within Quality Effectiveness.

3.5 Access South CBU

Access South CBU is currently holding 1 risk which is exceeding the appetite within the Quality Safety category.

4.0 North Cumbria Locality Care Group



In total as at end of December 2021 the North Cumbria Locality Care Group hold 47 risks, 17 risks within the risk appetite and 29 risks which have exceeded the risk appetite and one below the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 7 risks on the North Cumbria Corporate Group risk register. 3 risks are within the risk appetite and 4 risks have exceeded the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1799v.16	Due to upcoming retirement and departure of several medical staff, there is a risk that there will not be a sufficient level of consultant cover across many services in North Cumbria. If not addressed services will struggle to operate at a level which is safe and/or timely in order to meet patient need.	Quality Safety (6-10)	20	4	5	Stuart Beatson
1801v.5	There is a risk that the current qualified vacancy rate is impacting across the inpatient units. This would lead to an impact on the use of agency staff being used.	Quality Effectiveness (6-10)	16	4	4	David Muir
1946v.3	Due to the number of nursing vacancies across the three CBU's i.e. Specialist CYPS, Inpatients and Access and Community, there is a risk that	Quality Safety (6-10)	16	4	4	David Muir

	staffing levels could reduce to levels which would compromise patient care and quality.					
2107v.1	Because of the lack of sustainable AC/RC cover on Yewdale Ward and a minimal MDT function, there is a risk that patient and staff safety may be compromised.	Quality Safety (6-10)	15	5	3	Stuart Beatson

4.1 North Cumbria Locality Corporate Business Units

The 3 CBU's within the North Cumbria Locality currently hold a total of 40 risks. 25 of those risks have exceeded a risk appetite. The risks in this locality were last reviewed in the CDT-R meeting held on the 28th June 2021. These risk will be reviewed again at the CDT-R meeting to be held on the 25th April 2022. (Please note CDT-R meetings were stood down for a time in 2021. Six monthly Quality Risk Reports are being provided by the Risk Management Lead to each Locality to assist with quality issues with existing risks in the absence of this meeting).

4.2 Community/ Access North Cumbria CBU

Community/ Access North Cumbria CBU currently hold 14 risks. 0 risks are below the risk appetite, 5 risks are within the risk appetite and 9 risks are exceeding the risk appetite. The Appetite Categories for the 9 risks exceeding the appetite are 6 within Quality Safety and 3 within Quality Effectiveness.

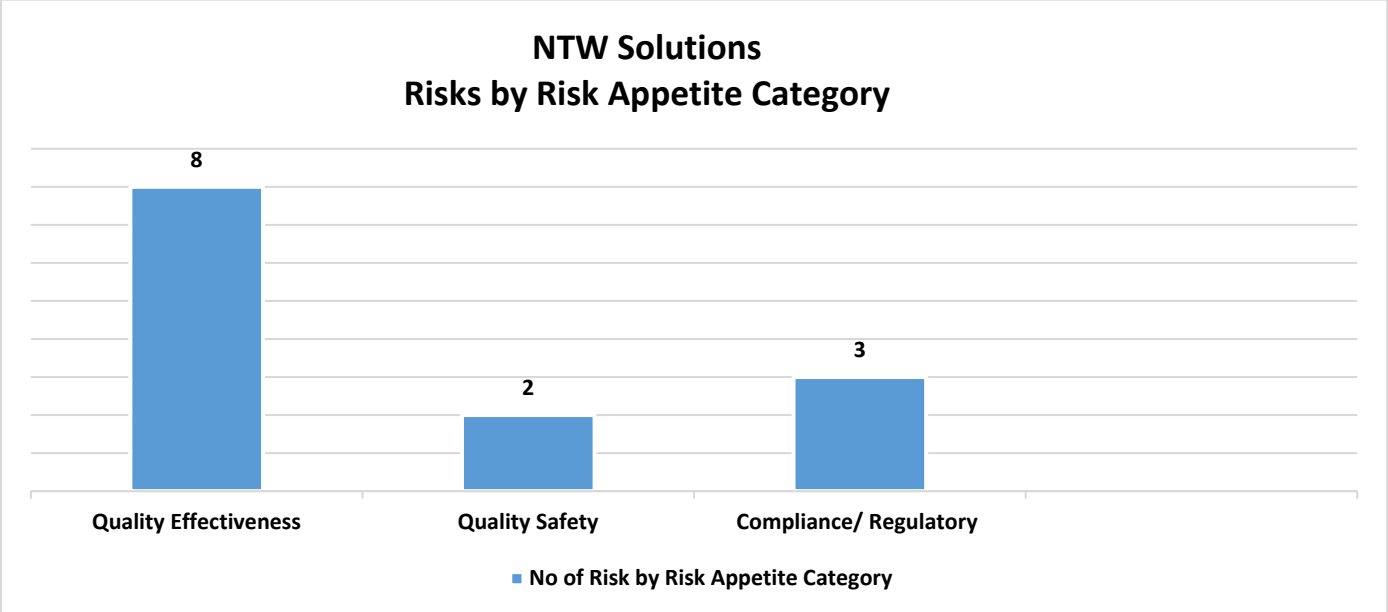
4.3 Inpatient North Cumbria CBU

Inpatient North Cumbria CBU is currently holding 9 risks. 0 risks are below the risk appetite, 3 risks are within the risk appetite and 6 risks are exceeding the risk appetite. The Appetite Categories for the 6 risks exceeding the appetite all are within Quality Safety.

4.4 Specialist Children and Young People's CBU

Specialist Children and Young Peoples CBU is currently holding 17 risks, 1 risk is below the risk appetite, 6 risks are within the risk appetite and 10 risks are exceeding the risk appetite. The Appetite Categories for the 10 risks exceeding the appetite are 9 within Quality Safety and 1 within Quality Effectiveness.

5.0 NTW Solutions



In total as at end of December 2021 the NTW Solutions hold 13 risks. 10 risks within the risk appetite and 3 risks have exceeded the risk appetite and there are no risks below the risk appetite. All risks are being managed within the NTW Solutions and no requests to escalate to BAF/CRR have been received.

There are 5 risks on the NTW Solutions Corporate risk register. 4 risks are within the risk appetite and 1 risk has exceeded the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1812v.23	If significant numbers of staff are unavailable due to Coronavirus this could lead to a significant impact on all services across the Company affecting service delivery / quality and the ability to fulfil contracted obligations.	Quality Effectiveness (6-10)	15	3	5	Malcolm Aiston

5.1 NTW Solutions Divisions

The 4 Divisions within the NTW Solutions currently hold a total of 8 risks. 6 risks are within the risk appetite and 2 risks have exceeded a risk appetite. The risks in this locality were last reviewed in the CDT-R meeting held on the 22nd November 2021. These risks will be reviewed again at the CDT-R meeting to be held on the 22nd May 2022. (Please note CDT-R meetings were stood down for a time in 2021. Six monthly Quality Risk Reports are being provided by the Risk Management Lead to each Locality to assist with quality issues with existing risks in the absence of this meeting).

5.2 NTW Solutions Transactional Services

NTW Solutions Transactional Services currently hold 5 risks. 0 risks are below the risk appetite, 4 risks are within the risk appetite and 1 risk is exceeding the risk appetite within the Quality Effectiveness category.

5.3 NTW Solutions Estates and Facilities

NTW Solutions Estates and Facilities currently hold 3 risks. 0 risks are below the risk appetite, 1 risk is within the risk appetite and 2 risks are exceeding the risk appetite. The Appetite Categories for the 2 risks exceeding the appetite are 1 within Quality Effectiveness and 1 within Compliance/Regulator.

5.4 Estates and Facilities

Estates and Facilities currently holds 1 risk. This risk is within the risk appetite.

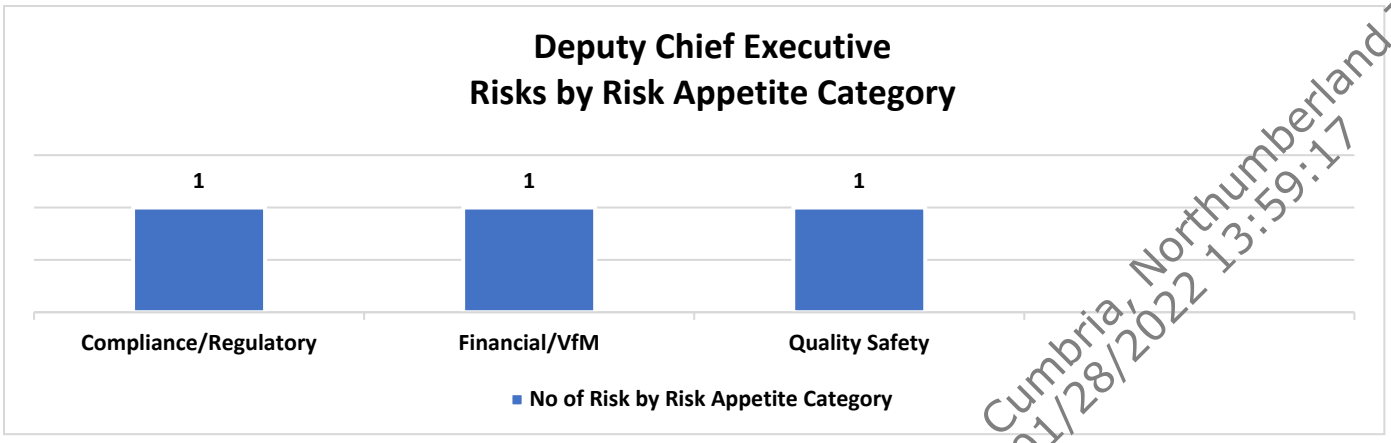
5.5 Pharmacy

Pharmacy currently holds 1 risk. This risk is within the risk appetite.

6.0 Executive Corporate

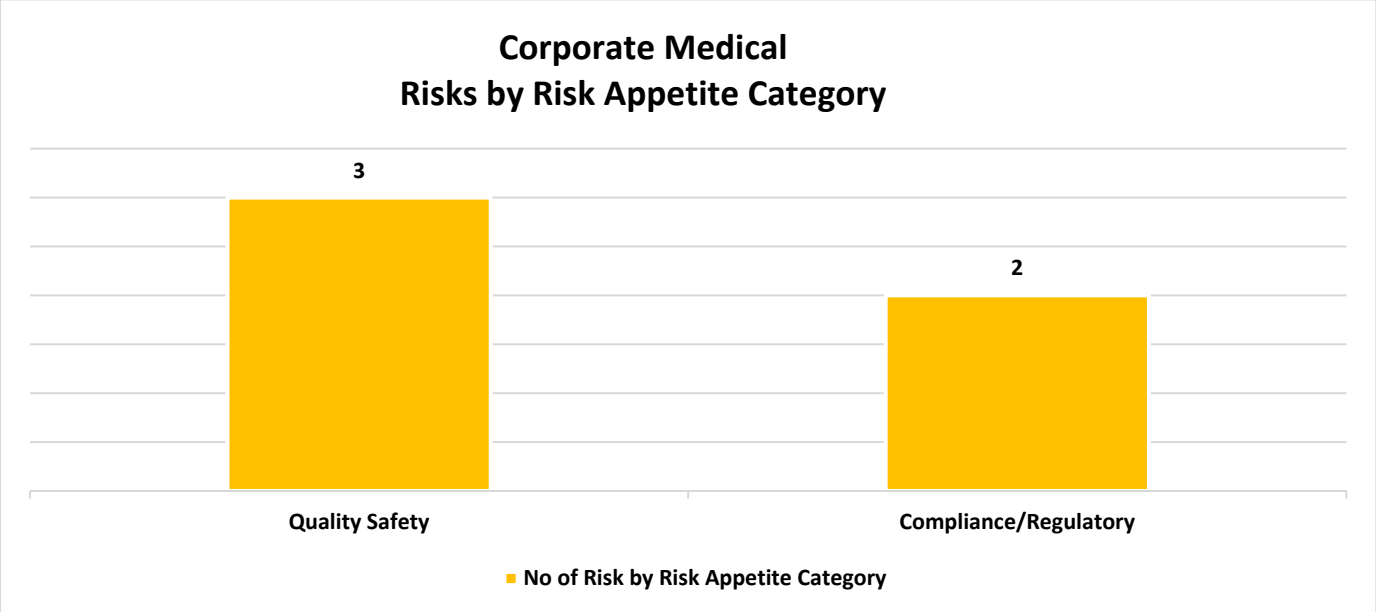
The Chief Executive as at end of December 2021 holds 1 risk. 1 risk is within the risk appetite. All risks are being managed within the Chief Executive's Office and no requests to escalate to BAF/CRR have been received.

7.0 Deputy Chief Executive



The Deputy Chief Executive as at end of December 2021 holds 3 risks within the risk appetite. 0 risks are below or exceeding the risk appetite. All risks are being managed within the Chief Executive's Office and no requests to escalate to BAF/CRR have been received.

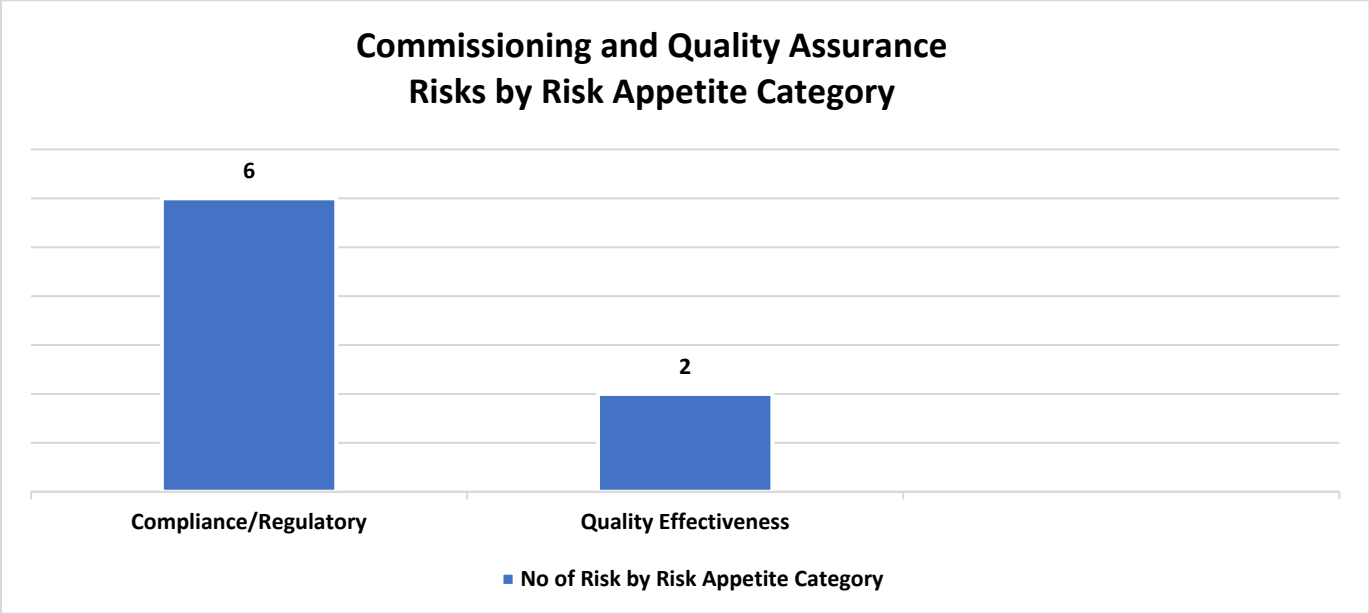
8.0 Corporate Medical Directorate



The Executive Medical Director as at end of December 2021 holds 5 risks, 3 risk are within the risk appetite and 2 risks are exceeding the risk appetite. Information in relation to breached risks are given below. All risks are being managed within the Medical Directorate and no requests to escalate to BAF/CRR have been received.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
2048v.1	There is a risk of unauthorised access or data breach resulting in Trust data being accessible by a third party, either accidentally through misconfiguration of the system, or deliberate act (eg. hacking) exploiting any weaknesses in the system design.	Compliance/Regulatory (6-10)	15	5	3	Simon Walker
2073v.2	Incidents of leaks and blocked toilets within the pharmacy department at SNH site. Potential health concern which could present infection control risk to staff and patients resulting in Pharmacy closure.	Quality Safety (6-10)	12	4	3	Janet Green

9.0 Commissioning and Quality Assurance



The Executive Director of Commissioning and Quality Assurance as at end of December 2021 holds 8 risks, 4 risks within the risk appetite and 4 risks which have exceeded a risk appetite. All risks are being managed within Commissioning and Quality Assurance Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1172v.27	Increased risk of security threats coupled with increasing type and range of device access to the network linked to technology developments increasing attack vectors and increased sophistication of exploits.	Compliance/ Regulatory (6-10)	12	4	3	Jon Gair
1576v.15	Data leakage risk of Trust Users transferring sensitive information via insecure methods or to untrusted destinations. This is likely to be via data sharing methods such as unencrypted USB drives, e-mail or personal cloud storage facilities (such as drop box, google drive, personal one drive etc)	Compliance/ Regulatory (6-10)	15	5	3	Jon Gair
1655v.23	Subject Access Requests: There is a risk of non-compliance with the reduced	Compliance/ Regulatory (6-10)	12	3	4	Angela Faill

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	time frame (1 month). In the absence of electronic systems, the task is labour intensive and wholly reliant on human resource. Therefore, increasing the risk of not meeting the legislation timeframe and error during the process which in turn breaches confidentiality or serious harm.					
1719v.14	A number of systems that are relied upon by the Trust are running on unsupported software that is no longer receiving security updates or patches. There is a risk that unknown exploits take over this machine, bypassing any security controls in place. The systems this includes are the following NTW-SP which is running an old version of Windows server and SQL database, currently running Sharepoint service for Informatics staff.	Compliance/ Regulatory (6-10)	12	4	3	Jon Gair

10.0 Workforce and Organisational Development

The Executive Director of Workforce and Organisational Development as at end of December 2021 holds 3 risks. There are 2 risks that are within the risk appetite and 1 risk exceeding the risk appetite. No risks to escalate to the BAF/CRR have been received.

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

11.0 Chief Nurse

The Chief Nurse as at end of December 2021 holds 4 risks. 2 risks are within the risk appetite and 2 risks which exceed the risk appetite. All risks are being managed within Nursing & Chief Operating Officer Directorate and there have been no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1758v.13	Due to several incidents occurring whereby, patients have been able to remove light fittings and gain access to a wire in the seclusion room and in a number of ward areas a ligature risk has been identified. The potential risk could result in serious harm to the patient	Quality Safety (6-10)	15	5	3	Stewart Gee
1821v.10	Due to several incidents occurring whereby, patients have been able to insert	Quality Safety (6-10)	15	5	3	Stewart Gee

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	knotted items into plug holes in sinks, fill with water causing the knot to swell and anchor into position, a ligature risk has been identified. The potential risk could result in serious harm to the patient					

12.0 Chief Operating Officer

The Chief Operating Officer as at end of December 2021 holds 2 risks. 2 risks which exceed the risk appetite. All risks are being managed within Chief Operating Officer Directorate and there have been no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1220v.29	Women of childbearing age are prescribed valproate without appropriate awareness of the risks involved. Risk identified in POMH-UK 15a Bipolar Disorder audit results, baseline assessment of NICE CG192 and MHRA Patient Safety Alert NHS/PSA/RE/2017/002	Quality Safety (6-10)	15	5	3	Ramona Duguid
1611v.26	It is important to identify patients who have a swallowing difficulty and the risk it poses. Patients who have a swallowing risk require appropriate assessment and for staff to recognise the	Quality Safety (6-10)	15	5	3	Ramona Duguid

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	potential risk off dysphagia therefore accessing and referring to the SALT team. The impact of this risk is on patient safety.					

13. Emerging Risks

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

Yvonne Newby
Risk Management Lead
10th January 2022

Appendix 4

Internal Audit Plan					
	2021/2022				
0	Q1	Q2	Q3	Q4	BAF/Directorate Ref
Governance, Risk and Performance					
Risk Management & Board Assurance Framework				*	BAF
Governance Arrangements Ethical Committee and Long-Term Segregation and Prolonged Seclusion Review Panel			*		N/A
Finance, Contracting & Capital					
Key Finance Systems			*		BAF
Pre- Employment Checks	*				N/A
International Recruitement		*			BAF
IM&T Systems & Projects					
Data Centre Security		*			N/A
Servelec Contract Management			*		BAF
Patient Network Security			*		N/A
Safeguard System Security				*	N/A
Penetration Test - BigHand System		*			N/A
Information Governance					
DSP Toolkit - Follow up	*				Directorate 1637
DSP Toolkit 2022 Submission				*	Directorate 1637
Data Quality					
Performance Management & Reporting		*			BAF 1688
Quality & Clinical Governance					
Consent to Examination or Treatment	*				BAF
Follow Up Audits					
All final audit reports issued with an assurance level of 'Reasonable' and 'Limited' will be followed up (once management have confirmed that all recommendations have been implemented). Furthermore, a year end exercise will be undertaken to review the status of all high-graded recommendations raised during the year.					
Audit Management					
•Annual Planning •Audit Committee Reporting & Attendance •Head of Internal Audit Annual Report & Opinion •Management & External Audit Liaison					

Review Area - Additional Assurances and Advisory	2021/2022				
	Q1	Q2	Q3	Q4	BAF/Directorate Ref
Governance, Risk and Performance					
Lone Working				*	N/A
COVID 19 Response		*			BAF 1687 BAF 1852
Finance, Contracting & Capital					
Financial Control		*			BAF 1762
Business change				*	N/A
NHS-Led Provider Collaorative			*		BAF 1831 BAF 2041
Human Resources & Workforce					
Personal Staff Attack Alarms	*				N/A
eRoster				*	N/A
Data Quality					
Delivering the Data Quality Improvement Plan		*			N/A
Quality & Clinical Governance					
Mental Health Act - Renewal of Detention/CTO		*			BAF 1691
Serious Incident - Action Planning	*				BAF
Complaints Action Planning	*				BAF
Clinical Risk Assessment				*	N/A
IM&T Systems & Projects					
Health Information Exchange (contingency)				*	BAF
Cumbria Records Scanning Project Review			*		N/A
NWT Solutions					
DSP Toolkit	*			*	N/A
Rostering and Overtime			*		N/A
Security		*			N/A
Right to Work and DBS	*				N/A

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Appendix 5

Clinical Audit Plan					
	2021/2022				
Review Area	Q1	Q2	Q3	Q4	BAF/SA/Directorate (DIR) Ref
Must Do Clinical Audits - Re audit					
CA-21-0011 - Annual Seclusion Audit 20-21	*				BAF - 1694v.17 (SA.5)
CA-18-0003 - Clinical Supervision Audit	*				BAF - 1688v.36 (SA.5)
CA-20-0005 - POMH-UK Topic 20a: Improving the quality of valproate prescribing in adult mental health services					N/A
CA-21-0002 - Physical Health Monitoring following Rapid Tranquilisation	*				BAF - 1688v.36 (SA.5) DIR - 1637v.27
Prescribing Observatory for Mental Health (POMH-UK) Topic 19b Prescribing antidepressants for depression in adults		*			N/A
CA-19-0034: Medication Summaries and Discharge Letters		*			DIR - 1038v.23
Nutrition policy audit			*		N/A
Prescribing Observatory for Mental Health (POMH-UK) Topic 1h & 3e Prescribing high dose and combined antipsychotics				*	N/A
Should Do Clinical Audits					
Medicines Management					
The safe use of opiates within CNTW (PGN-PPT-PGN 18)	*				N/A
The use of zuclopenthixol acetate (Accuphase) within CNTW – Re-audit (PPT-PGN- 27)			*		N/A
CA-19-0017 - Safe Prescribing and administration of insulin					N/A
CA-19-0033 - Caseload Management - Central Locality		*			BAF 1836 v.7 (SA.4)
CA-19-0035 - Trust wide Safeguarding Adults Audit		*			BAF 1683v.19 (SA.1.4) BAF 1762v.12 (SA.1) BAF 1836v.8 (SA.4) BAF 1694v.16 (SA.5)
CA-20-0014 - Benzodiazepine and Z-drug Prescribing (PPT-PGN-21) re-audit		*			
CA-20-0022 - Consultant review on admission audit		*			
CA-20-0025 - Adherence to ECTAS Standards on Time to Reorientation (TTR) Post-ECT		*			
CA-21-0010 - Long-term Segregation - (Annual Report 2020 to 2021)		*			BAF 1688v.34 (SA.5)
High Dose and Combined antipsychotics Trust wide audit				*	N/A
Safe Prescribing of Valproate (PPT-PGN-25)				*	BAF
CA-20-0021 Medicines Reconciliation	May-21				DIR - 1288v.35
Trust Wide					
NICE COVID-19 Rapid Guidelines, including Rapid Evidence Summaries Review 21-22.	*				BAF
Monitoring of Prolactin in Patients Prescribed Antipsychotic Medications and the Management of Raised Prolactin Levels in Rehabilitation Wards			*		N/A
To determine compliance with fasting guidelines in patients undergoing ECT treatment in CNTW NHS Foundation Trust.			*		N/A
CA-20-0024 A Weight Off Your Mind group audit – Weight management when prescribing antipsychotics	May-21				N/A
CA-20-0025 Time to re-orientation following ECT	May-21				N/A
CA-20-0027 Transition Referrals to the Adult ADHD team via CYPS			Nov-21		N/A
CA-20-0030 Prescribing Valproate in Child-Bearing Women in Under 18s		Aug-21			DIR -1220v.28
CA-20-0031 Audit of Benzodiazepine and Z-drug prescribing in 3TTs against the BNF guidelines and Trust PPT PGN-21)	May-21				N/A

NICE (Implementation)					
Sepsis: Audit of Compliance to Trust and NICE Guidance.	*				BAF
NG87 ADHD in Adult ADHD Services				*	BAF
TA 217 Memantine Prescribing in NTW against NICE Guidelines Re-Audit			*		BAF
QS95 / CG185: Psychological Therapy Use for Patients with Bipolar Disorder in a Large NHS Mental Health Trust (Re-Audit)			*		BAF
CG103: Audit of Clinical Practice against Delirium Standards: Re-Audit			*		BAF
NICE NG134: Depression in CYPS Re-Audit (CA-19-0022 & CA-19-0023 Combined)	*			*	BAF
CYPSS CPA Care and Treatment audit				*	N/A
Clustering			*		N/A
CA-20-0003 Caseload Management				*	BAF
Trust Priotires Audits by Localities					
North Locality					
Clinical Standards Review * Specific information will be provided at scoping meeting to complete registration form				*	BAF
South Locality					
CA-20-0022 Consultant review audit	May-21				N/A
CA-20-0028 Core Assessment audit within South Tyneside CTT			Nov-21		BAF 1694v.17 (SA.5) BAF 1836v.10 (SA.4) BAF 1688v.37 (SA.5) DIR -1160v.23 DIR - 1497v.22
Central Locality					
CA-20-0012 Clinical Audit of Unallocated Cases awaiting Treatment					N/A
North Cumbria Locality					
CA-20-0018 Care Co-ordination Audit – North Cumbria Children & Young People's Services Re-audit	May-21				BAF - 1836v.8 (SA.4) DIR -1946v.3
CA-20-0019 Risk Formulation	Jun-21				N/A
CA-20-0020 Care Planning	May-21				BAF 1836v.8 (SA.4)
CBU Priorities					
North Community					
Audit of over BNF Limits (to take place for assurance)		*			BAF
North Inpatient and Learning DiBAFbilities & Autism					
Audit on patient debrief post tertiary intervention in Inpatient & Learning Disability & Autism North	*				BAF
North Cumbria Inpatient					
Co-production: Formulation, Care Plan, Safety Plan, GTKY, Training	*				BAF
North Cumbria Access & Community					
Re-audit of anticholinergic burden in patients referred to the Old Age Psychiatry Department with memory impairment		*			BAF
Re-audit of Care Planning Audit - North Cumbria			*		BAF 1836v.8 (SA.4)
Re-audit of Risk Formulation Audit - North Cumbria				*	BAF
South Inpatient					
An audit to assess Physical Health Monitoring compliance with CNTW(C) 29		*			N/A
South Community					
CA-21-0021: Getting to Know You Process and recording within Adult Services	*				DIR 1637v.27
South Access					
Demobilisation of Wear Recovery audit	*				BAF

Ongoing Audits from the 20-21 Programme					
CA-18-0025 National Audit of Inpatient Falls (NAIF) Continuous Audit					N/A
CA-20-0029 National Audit of Inpatient Falls (NAIF) Facilities Audit Jan-20				*	N/A
CA-19-0010 National Clinical Audit of Psychosis (NCAP) Spotlight Audit 2: EIP Re-Audit 19-20		Aug-21			DIR 1637v.27
CA-20-0006 National Clinical Audit of Psychosis (NCAP) Re-Audit of EIP Services 20-21		Jul-22			DIR 1637v.27
CA-20-0023 National Clinical Audit of Psychosis (NCAP) Spotlight Audit 20-21 Physical Health & Employment	Fed 22				N/A
CA-20-0002 NICE QS188 Coexisting Severe Mental Illness & Substance Misuse		Jul-21			N/A
CA-20-0005 Prescribing Observatory for Mental Health (POMH-UK): Topic 20a: Prescribing Valproate		Jul-21			N/A
CA-20-0026 Prescribing Observatory for Mental Health (POMH-UK): Topic 18b: Use of Clozapine	Jan-22				N/A
CA-19-0037 National Audit of Inpatient Falls (NAIF) Facilities Audit Jan-20		Jun-21			N/A
NICE Implementation					
CA-19-0022Re-Audit NICE (Implementation) NICE CG28: Depression in CYPS	May-21				BAF
Deferred Audits from the 20-21 Programme					
CA-19-0036 National Audit of Care at the end of Life (NACEL) Stage 3	*				N/A
Care Coordination					N/A
CA-20-0011 Lower Urinary Tract Infections: audit of compliance to Trust and NICE guidance				*	N/A
CA-20-0016 National Audit of Dementia – Spotlight Audit: Community- Based Memory Clinical Services	*				N/A
Care Planning and personalisation of care planning.					N/A
Re-audit Prescribing Observatory for Mental Health (POMH-UK) POMH 14c Alcohol detoxification	*				N/A
CA-19-0024 NICE (Implementation) Ante & Postnatal Mental Health incorporating Contraception (CG192 & QS129)	*				BAF
NICE (Implementation) QS95 & CG185 Bipolar Disorder in Adults and the Provision of Psychological Therapies			*		BAF

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
2nd February 2022

Title of report	**Quarter 3 update - NHS Improvement Single Oversight Framework**
Report author(s)	**Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance** **Dave Rycroft, Deputy Director of Finance & Business Development**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning & Quality Assurance**

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

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

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

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

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

BOARD OF DIRECTORS

2nd February 2022

Quarterly Report – Oversight of Information Submitted to External Regulators

PURPOSE

To provide the Board with an oversight of the information that has been shared with NHS Improvement and other useful information in relation to Board and Governor changes and any adverse press attention for the Trust during Quarter 3 2021-22

BACKGROUND

NHS Improvement using the Single Oversight Framework have assessed the Trust for Quarter 3 of 2021-22 as segment 1 – maximum autonomy.

A summary of the Trust ratings since the start of financial year 2016-17 are set out below:

	Q1 & 2 16-17	Q3 & Q4 16-17	Q1 – Q4 17-18	Q1 –Q4 18-19	Q1 & Q2 19-20	Q3 & Q4 19-20	Q1 – Q4 20-21	Q1 – Q3 21-22
Single Oversight Framework Segment	n/a	2	1	1	1	1	1	1
Use of Resources Rating	n/a	2	1	3	3	2	*2	*2
Continuity of Services Rating	2 (Q1) & 3 (Q2)	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Governance Risk Rating	Green	n/a	n/a	n/a	n/a	n/a	n/a	n/a

*Please note since Quarter 1 2020/21 the Use of Resources Rating is related to Quarter 4 2019/20 due to suspension of this rating during COVID-19.

Key Financial Targets & Issues

A summary of delivery at Month 9 against our high level financial targets and risk ratings, as identified within our financial plan for the current year, and which is reported in our monthly returns is shown in the tables below (Finance returns are submitted to NHSI on a monthly basis):-

	Year to Date			Year- End		
Key Financial Targets	**Plan**	**Actual**	**Variance/ Rating**	**Plan**	**Forecast**	**Variance/ Rating**
Risk Rating	n/a	n/a	n/a	n/a	n/a	n/a
I&E Surplus/(Deficit)	£0.2m	£0.4m	£0.2m	£0.0m	£0.0m	£0.0m
FDP - Efficiency Target	n/a	n/a	n/a	n/a	n/a	n/a
Agency Ceiling / Agency Spend	n/a	£14.8m	n/a	n/a	£19.9m	n/a
Cash	£53.0m	£73.6m	£20.6m	£45.0m	£50.0m	£5.0m
Capital Spend	£35.2m	£23.4m	(£11.8m)	£47.3m*	£40.5m	(£6.8m)
Asset Sales	£4.0m	£0.0m	(£4.0m)	£4.2m	£4.0m	(£0.2m)

'* The Trust is awaiting a variation to be actioned which will reduce the capital plan by £6.1m

Risk Rating

The interim financial arrangements put in place during COVID-19 have resulted in the suspension of the Use of Resources rating including the requirement for a Board Assurance statement to be completed if a trust is reporting an adverse change in its forecast out-turn position.

Workforce Numbers

The workforce template provides actual staff numbers by staff group. The table below shows a summary of the information provided for Quarter 3 2021-22. Workforce returns are submitted to NHSI on a monthly basis.

SUMMARY STAFF WTE DETAIL	M7	M8	M9
	Actual WTE	Actual WTE	Actual WTE
Total non-medical - clinical substantive staff	4,974	5,016	5,021
Total non-medical - non-clinical substantive staff	1,939	1,957	1,984
Total medical and dental substantive staff	408	415	408
Total WTE substantive staff	**7,321**	**7,388**	**7,413**
Bank staff	315	312	303
Agency staff (including, agency and contract)	366	369	360
Total WTE all staff	**8,002**	**8,069**	**8,076**

Agency Information

The Trust has to report to NHS Improvement on a weekly basis, the number of above price cap shifts and also on a monthly basis the top 10 highest paid and longest serving agency staff. However, the reporting of the top 10 highest paid and longest serving agency staff is suspended as part of the COVID-19 interim arrangements.

The table below shows the number of above price cap shifts reported during Quarter 3 2021-22.

	October	November	December
Staff Group	4/10 –31/10	1/11 -5/12	6/12 – 2/1
Medical	237	191	292
Qualified Nursing	650	870	350
Nursing Support	414	537	390
TOTAL	**1,301**	**1,598**	**1,032**

At the end of December the Trust was paying 16 medical staff above price caps (5 consultants, 2 associate specialists 2 specialty doctors and 7 junior doctors). 2 of the consultants are being paid over £100 per hour so are separately reported to NHS Improvement. The weekly average number of shifts reported over the cap for December was 73 medical shifts, 88 qualified nursing shifts and 98 nursing support shifts.

GOVERNANCE

There is no longer a requirement to submit a governance return to NHS Improvement; however, there are specific exceptions where the Trust are required to notify NHS Improvement and specific items for information, it is these issues that are included within this report.

Board & Governor Changes Q3 2021-2022

Board of Directors:

Peter Studd – Non-Executive Director left
Brendan Hill – Non-Executive Director joined
Leslie Nelson - Non-Executive Director joined

Council of Governors:

No change

Outgoing Governors:	Present vacancies
Nil	Carer Governor (Adult Services) Carer Governor (Neuro Disability Services)

Never Events

There were no never events reported in Quarter 3 2021 - 2022 as per the DH guidance document.

Other items for consideration

As well as the items noted in the report above the Trust also completes submissions to NHSI for the following data:-

Weekly
- Total number of bank shifts requested/total filled (from October 17)

Monthly
- Care Hours Per Patient Day.
- Estates and Facilities Costs

Annually
- NHSI request information for corporate services national data collection on an annual basis. This data includes information in relation to Finance, HR, IM&T, Payroll, Governance and Risk, Legal and Procurement. This information will be used to update information within Model Hospital on an annual basis.

Carter Review
- Community and Mental Health (Productivity) – Community services
- Corporate Benchmarking – First submission in 16/17.

RECOMMENDATIONS

To note the information included within the report.

Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance
Dave Rycroft, Deputy Director of Finance & Business Development
January 2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
Wednesday 2nd February 2022

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

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

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

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

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

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

Infection Prevention and Control (IPC) Board Assurance Framework
Report for the Board of Directors meeting
Wednesday 2nd February 2022

1. Executive Summary

The IPC Board Assurance Framework issued by NHSEI in May 2020 is designed to help providers assess against the Infection Prevention and Control guidance for Covid-19 as a source of internal assurance that quality standards are being maintained. The BAF has been updated on the 24 December and new areas of compliance have been highlighted by NHSEI in the attached document. The new inclusions build on the work we have done to date.

This attached report covers the Q3 period October to December 2021, during which time the Trust experienced a significant surge in Covid infections in patients admitted to our wards from the community, this activity mirrored the sudden increase in community prevalence following the relaxation of government restrictions coupled with a new variant.

During this quarter, 10 Covid outbreaks were declared and reported to NHSEI affecting patients and staff, and four outbreaks affecting staff only.

From the beginning of December there had been a steady increase in the number of reported staff household cases who had tested positive and subsequent staff who have had to self-isolate. This increase coincided with the increase in local cases in the community and the new Omicron variant circulating.

The tool provides assurance to Trust Boards that

- any areas of risk are identified and show corrective actions taken in response

- organisational compliance has been systematically reviewed for other potential Nosocomial or Hospital Acquired Infections (HAI's).

During October to December 2021 performance against the self-assessment for the Trust has been tested via the routine review of standards in all settings.

2. Nosocomial (Healthcare Acquired Infection) Covid Infections

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

At the beginning of January 2022 the NHS/I has acknowledged *'that whilst the patient(s) has been in the care of NHS commissioned services, the patients may have been on a period of leave (authorised or not); during this leave period the patient may have been exposed to a positive contact; and during this leave period the patient may not have followed COVID restrictive*

practices at all times –mask wearing in public places, hand washing and social distancing'. Within CNTW each positive patient case is reviewed to establish their close contact information which includes escorted and unescorted leave to understand if the Covid-19 infection can be attributed to their activity off the ward.

During Quarter 3, October to December 2021, there have been a total of 78 cases of Covid-19 infections reported, see table:

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* ?	1			
3 – 7 days after admission*?		4		
8-14 days after admission*?			7	
15 or more days after admission*?				66*

These cases have been reviewed to identify if there has been any activity off the ward in the wider community to determine if the positive case can attributed to community transmission.

Out of the 77 reported nosocomial cases, Root Cause Analysis has been conducted on all cases:

- 12* patients following close contact information were attributed to their activities off the ward through unescorted leave or linked to positive households/families.
- 1 indeterminate however likely to be community acquired but no admission swab was taken.
- 62 were identified through surveillance screening as part of the outbreak management and were caused as a result of close contact with patients who were positive on admission or within 7 days of admission

Local Learning has been fed into wider IPC Assurance meetings and Lessons learnt briefings

3. <u>Compliance</u>

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

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

- Some wards have reported patient refusal for routine weekly PCR testing. Patients who have access to unescorted leave pose a risk when returning to the ward and has resulted in Nosocomial spread.

- Wearing of face masks by patients to help reduce the transmission of Covid-19 positive areas continues to be risk assessed on a case-by-case basis considering communication challenges, ability to comply with social distancing and ligature risk from mask types.

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

In addition, actions to support assurance of the self-assessment include:

- Covid-19 Gold Command, led by the Executive Director of Nursing and Chief Operating Officer has continued to operate as a hub for rapid decision making in response to guidance impacting on safe clinical practices, Covid-19 secure workplaces and relaxation of lockdown.

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

- Reports to Covid-19 IMG by Group Nurse Director Safer Care / Director for Infection Prevention and Control (DIPC) on national and emerging IPC guidance and implications, PPE position, staff, and index case testing.

- IPC Assurance meetings during this period have changed to monthly. Membership includes DIPC / Group Nurse Director for Safer Care, Group Medical Director Safer Care, IPC Team, Locality Group Nurse Directors and Deputy Director of Communications.

- Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff continues. All results logged via Trust portal, however as the test is not mandatory it is noted that compliance with this continues to be variable despite encouragement. Compliance with LFT testing is discussed at each outbreak meeting.

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

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

- All clinical areas in both inpatient and community complete the updated Infection prevention and control Covid-19 management checklist 1.4 (February 2021). Locality Group Nurse Directors review monthly through Locality Quality & Standards meetings.

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

- IPC team continue to undertake scheduled and adhoc ‘Teams’ Meetings with Clinical Nurse Managers, Ward Managers and clinical care groups to discuss complex cases, offer support and guidance for the practical application of 14-day isolation of patients.
- IPC undertake visits of all outbreak areas to review donning and doffing and provide advice and support.
- Specific training sessions with AHPs have been facilitated as part of learning from an outbreak in relation to use of shared equipment.
- IPC Team have continued where possible and to minimise transmission, to make ‘visit/walkabouts’ to hospital and some community service sites to monitor hand washing, social distancing, advise on appropriate use of PPE.
- IPC Team have delivered Covid-19 training via teams to clinical and non-clinical on request.
- The comprehensive roll out of Fit Testing of FFP3 masks continues to be led by the Academy Physical Health Leads to staff, including the refit of new models of mask and fit testing for PAM referrals, multiple failure referrals and those with work related difficulties.

5. <u>Conclusion</u>

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

Anne Moore
Group Nurse Director Safer Care, Director of Infection Prevention and Control
January 2022

Classification: Official

Publication approval reference: C1501

Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Updates from version 1.6 are highlighted in yellow.

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of SARs-CoV-2 and other seasonal respiratory viruses, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

Infection prevention and control board assurance framework

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

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan. • health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. • Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been	All admissions into the trust are screened on day1,3, and day 5 following admission and every7days thereafter. Appropriate care plan re: isolation until result known. Documented in RIO progress notes. All CNTW patients are nursed in single rooms. All rooms covid risk assessed for maximum occupancy. Signage in place. Social distancing maintained in all areas. Natural ventilation is encouraged in all areas. Use of PPE in line with PHE and trust guidance.	Not all rooms have en suite facilities. Specific advise given on how to manage shared facilities to avoid the spread of infection.	

approved through local governance procedures, for example Integrated Care Systems. • if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. • if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services. • the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas. • resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • the application of IPC practices within this guidance is monitored, eg: ○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination. • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board. • the Trust Board has oversight of ongoing outbreaks and action plans. • • the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	All national guidance reviewed by DIPC, decisions discussed and agreed via IMG. Covid secure risk assessments completed by the Safety, Security and risk Team. Considered on a case by case basis Transfers of COVID-19 positive patients is limited as much as possible. Data circulated to Executive Team IMG members daily reviewed and signed off by Gold Command led by Executive Director of Nursing and DIPC. Gold command and IMG COVID-19 resources on trust intranet, including COVID-19 support pack inpatient services. Spot check visits by IPC tea members to monitor compliance, in addition to individual case discussions. IPC BAF discussed at IPC assurance meeting. Reported to the board of directors 3 monthly. Gold command and IMG. Programme in place to fit test al staff to more than one FFP3 mask manufacturer		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. • Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. • if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses. • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. • a minimum of twice daily cleaning of: ○ patient isolation rooms. ○ cohort areas. ○ Donning & doffing areas ○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails.	NTW Solutions reviewing current cleaning standards against National standards for Cleanliness. Information and cleanliness scores presented at trust IPCC meeting. Decontamination and terminal decontamination included in Trust guidance in line with PHE advice. All areas throughout the trust utilise neutral purpose detergent and chlorine based disinfectant. Domestic staff instructed in manufacturers guidance for the dilution and contact time. Domestic staff instructed in the required standards with particular attention to bathrooms/toilets. All isolation rooms cleaned a least twice daily. Ward staff additional touch point cleaning. Ward managers advise domestic teams when to enter rooms for	North Cumbria Locality where they provide domestic services to our premises. Tristel Fuse used.	

○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea. • A terminal/deep clean of inpatient rooms is carried out: ○ following resolutions of symptoms and removal of precautions. ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ○ following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: ○ between each use. ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	cleaning following patient movement or clinical interventions. Cleaning carried out in accordance with IPC standards and national guidance. Reusable equipment decontaminated appropriately and effectively between and after use in line with Trust policy. Monitored via Cleanliness audits and IPC visits. Rooms in CNTW are not typically mechanically ventilated and openable windows is the only method. Risk assessments completed in clinical areas. Ventilation encouraged by opening windows.		

• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Estates involved in all discussions		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and process are in place to ensure that:
• arrangements for antimicrobial stewardship are maintained
• previous antimicrobial history is considered
• the use of antimicrobials is managed and monitored:
  ○ to reduce inappropriate prescribing.
  ○ to ensure patients with infections are treated promptly with correct antibiotic.
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.
• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.
	Arrangements are in place and antibiotic prescribing is monitored.
	
	Incident reports submitted where antibiotics are prescribed.
	
	Antibiotic surveillance is reported to the IPCC quarterly.		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	All visits are via booked sessions. Welfare checks completed prior to the visit. A negative LFD test is required 24 hours prior to the visit. As part of outbreak management visiting is discussed. Visits can be allowed where there are extenuating circumstances and following discussion with IPC to put standards in place.		

• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. • visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Signage available at all sites reminding the use of Face masks/face coverings and maintaining social distancing PPE provided and designated covid risk assessed visiting rooms. Welfare checks prior to visits. Extenuating circumstances individually risk assessed by IPC and ward team. Visitors do not visit when AGPs in progress. Regular communications on personal protective behaviours in and out of work. Staff and Wellbeing resources available on trust intranet.		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage available at all sites reminding the use of Face masks/face coverings and maintaining social distancing.		

• infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved. • patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	Information shared between organisations as part of patient transfer. Community teams contact patients prior to the visit or appointment to establish any COVID-19 infection risks All admissions into the trust are screened on day1,3, and day 5 following admission and every7days thereafter. Appropriate care plan re: isolation until result known. Documented in RIO progress notes On admission all patients are informed of the use of masks to reduce the transmission of covid-19 and encouraged to wear them. Each patient risk assessed re ligature risks. Some patients do not wish to comply with social isolation or alternative mask use All patient nursed in single rooms	There are occasions when patients do not comply with isolation pending results	Triage via Bed Management clinical Team Staff wear full PPE at all times

• where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	All patients are informed of the use of masks to reduce the transmission of covid-19 and encouraged to wear them. All staff wearing face masks Staff are aware of the need for social distancing. Use of 2m floor spacers to prompt and remind staff re need for 2m distancing. Posters are on display in all wards/departments across the Trust. Covid risk assessments completed in all areas to identify room occupancy. Perspex screens are in place in reception areas where required following covid secure risk assessments. Guidance provided to community teams reduce social distancing to 1 metre to allow for All patients who develop symptoms are tested and isolated promptly with continued monitoring of the patient's physical health. Appropriate care plan re isolation until result known. Documented in Rio progress notes and alerts Patients who are symptomatic are isolated, if continue to display symptoms following negative result they will be retested. Reduced face-to-face appointments and increased use of technology.	This can be due to communication difficulties of sensory impairment or ligature risks of use of masks. Risk if ingestion The use of masks within some patient groups has been challenging.	**H**andovers and pre leave checklist acts as a prompt to ensure masks are available and understand the risks of community acquired infection**.**

	Staff check with the patient that they are well and symptom-free before appointment where possible to reduce risk of spread		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	All staff receive in-depth IPC training in induction into the trust. Visitors advised of IPC standards prior to visit as part of pre screening check. Targeted training sessions are provided in relation to PPE use, donning/doffing. Training records are maintained by the training facilitators. Adherence to national guidance is undertaken by routine checks by Clinical nurse managers and IPC team. PPE worn in accordance with trust and national guidance. Hand towel dispensers are available in all areas and are regularly maintained.		

• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Communication on personal uniform laundering as been cascaded via communication briefings. All staff displaying symptoms of covid-19 are advised to contact the central Absence line with the trust for advice and access PCR via the trust based testing team. Fact find meeting to identify if two or more positive cases linked to time and place. OB management policy implemented when two or more positive cases identified.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred,	On admission all patients are informed of the use of masks to reduce the transmission of covid-19 and encouraged to wear them. Each patient risk assessed re ligature risks. Some patients do not wish to comply with social isolation or alternative mask use. Social distancing in patient communal areas, day rooms/dining rooms.		

their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased	All areas compliant facilities to support isolation/cohorting Daily review as part of the covid handover checklist. All admissions into the trust are screened on day1,3, and day 5 following admission and every7days thereafter. IPC support and advise given on all infectious patients to clinical teams.		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance; • staff testing protocols are in place • there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	All Trust staff undertaking testing are appropriately trained Testing of both staff and patients is undertaken promptly (usually same day that symptoms are first noticed). Regular monitoring of testing turnaround times. All labs following letter from NHSE Mental Health to ensure rapid processing of tests for MH/LD settings. Reported daily via internal reporting mechanisms Screening takes place to rule out other infections/symptoms being displayed		

• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	All patients who develop symptoms are tested and isolated promptly with continued monitoring of the patient's physical health. Appropriate care plan re isolation until result known. Documented in RIO progress notes and alerts		
• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	All patients screened on day 1, 3 and day 5 and at 7 day intervals thereafter in accordance with national guidance. Patients screened in accordance with local guidelines and IPC screening guidelines. Information shared with receiving organisation prior to discharge.		
• those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Liaison with the care facility regarding isolation requirements as part of discharge planning arrangements.		
• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	ECT patients are screened prior to each treatment		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must	IPC Team are in daily contact with clinical areas regarding IPC processes and advising wards/teams where other infections are reported		

include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it.	Any changes to PHE guidance communicated to staff as soon as possible via the daily communications and Team meetings All waste related to suspected or confirmed COVID-19 cases is disposed of appropriately as infectious clinical waste into orange bags. Introduction of tiger waste for non-clinical areas for the disposal of face mask. Central management of PPE has been introduced to ensure adequate stock for all areas based on usage		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection.	All staff displaying symptoms of covid-19 are advised to contact the central Absence line with the trust for advice and access PCR via the trust based testing team. Staff tested in accordance wit national guidance Staff with additional needs are referred to occupational health for risk assessment Targeted training sessions are provided in relation to PPE use, donning/doffing.		

• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  ○ lead on the implementation of systems to monitor for illness and absence.
  ○ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce
  ○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19
  ○ encourage staff vaccine uptake.
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.
  ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups;
  ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications.
  ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.
  ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.
• vaccination and testing policies are in place as advised by occupational health/public health.
• staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.
• staff who carry out fit test training are trained and competent to do so.
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.
	Training records are maintained by the training facilitators.
	
	Positive close contact risk assessments completed on all positive staff. Any breach in IPC standards shared with IPC team and staff embers manager.
	
	All staff managed in accordance with national guidance.
	
	Risk assessments completed for all staff by line manager.
	Risk assessment includes the need for additional PPE eg FFP3 mask.
	
	Vaccination and testing in accordance with national guidance.
	
	HSE approved training session of upto 3 hours and be deemed competent by an external contractor approved in RPE training
	
	All testing done is recorded on a fit test report including those who have failed the test and those who are unsuitable for masks		

• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance. • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	All test reports are scanned to and inputted onto ESR. The data viewed as 'live' on the FFP3 dashboard which allows locality managers / clinical leads to receive the latest mask information for their staff groups. The original report is given to the managers for record keeping and those fit tested receive a business card with their mask and details on. Those who cannot undergo a fit test will be regarded as a failed fit test. Instructed not to enter areas where FFP3 masks are recommended or undertake duties where there are potential AGP's. Managers are asked to review any employees who falls into this category The data can be viewed as 'live' on the FFP3 dashboard which allows locality managers / clinical leads to receive the latest mask information for their staff groups. Recorded on ESR. Staff teams remain on their allocated areas with minimal movement. This includes Domestic Teams. Staff are aware of the need for social distancing. Use of 2m floor spacers to prompt and remind staff re need for 2m distancing. Posters are on display in all wards/departments across the Trust.		

	The Trust Covid19 Environmental working group has undertaken environmental risk assessments and recommended modifications required trust wide. Face masks are worn by all staff in all areas. Staff absence and well-being monitored via individual team managers and centrally through the Central Absence Line. Well-being checks undertaken Information is provided to staff at point of test explaining outcome of results i.e. negative and positive including ongoing support should symptoms worsen or re-occur. Welfare calls support staff to either return or onward referral to Occupational Health		

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
Wednesday 2 February 2022

Title of report	**People Committee Terms of Reference and Reporting Schedule**
Report author(s)	**Lynne Shaw, Executive Director of Workforce and OD**
Executive Lead (if different from above)	**As above**

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

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Provider Collaborative and Lead Provider	
People Committee	19.01.2022
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	10.01.2022
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
CDT – Digital	
Business Delivery Group (BDG)	

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

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

People Committee Terms of Reference and Reporting Schedule

Report to the Board of Directors
Wednesday 2 February 2022

1. Executive Summary

The first People Committee took place on Wednesday 19 January 2022. The attached Terms of Reference and Reporting Schedule were agreed at the first meeting.

Review to be undertaken in October 2022 after three meetings have been held.

2. Next Steps

Final approval by the Trust Board of Directors.

3. Risks/Mitigations

There are no risks associated with this report.

4. Recommendations

The Board of Directors is asked to approve the finalised Terms of Reference.

Lynne Shaw
Executive Director of Workforce and OD

26 January 2022

People Committee
Terms of Reference

Committee Name: People Committee

Committee Type: Standing sub-committee of Board of Directors

Timing & Frequency: The Committee will meet quarterly but may meet more frequently at the request of the Chair

Personal Assistant to Committee: Corporate Affairs Office

Reporting Arrangements: Minutes and Report from Chair to Board of Directors

Membership:	
Chair:	Non-Executive
Deputy Chair:	Non-Executive
Members:	Executive Director of Workforce and Organisational Development Chief Nurse Executive Medical Director Chief Operating Officer Executive Director of Commissioning and Quality Assurance One other Non-Executive Director (excluding Chair and Vice-Chair)
In Attendance:	Deputy Director of Workforce and OD Director of Communications and Corporate Affairs Group Nurse Directors x 4 (North, South, Central and North Cumbria) Deputy Medical Director (revalidation) Deputy Chief Nurse Two Governor representatives PA to Committee
Quorum:	Chair or Deputy Chair Two Executive Directors
Deputies:	Deputies required for all members by exception and with prior agreement of the Chair

Purpose:

In furtherance of the Trust's 2030 Strategy, the purpose of the Committee is to provide assurance to the Board with regard to workforce development and delivery of the Trust's Workforce Strategy. It will hold the ambition of being the CNTW focal point for discussion and examination of the challenges and opportunities in workforce development that will better enable the Trust and its partners to help improve the mental health and well-being of the people we serve.

Scope:

The committee will provide assurance to the Board with regard to workforce development and delivery of the Trust's Workforce Strategy, enabling its strategies, programmes, and plans to be delivered. In accordance with the ambitious purpose of the Committee, it will appropriately appraise the Board on how the Trust is influencing workforce development systemically with partners in line with the Trust's 2030 Strategy and by:

- Supporting the strategic direction and monitoring implementation programmes for all workforce and organisational development issues and service delivery in line with the wider Trust strategic objectives.
- Providing assurance to the Board of Directors that the organisation is compliant with relevant legislation, appropriate external requirements and policies.
- Reviewing, assessing and monitoring workforce risks in line with the Trust Board Assurance Framework (BAF), ensuring appropriate mitigation and escalation is in place.
- Reviewing workforce key performance indicators.
- Ensuring the Trust remains focused on attracting, developing and retaining the right people with the right skills in the right place at the right time.
- Receiving assurance with regard to working collaboratively with Trust localities to set the direction of the overall workforce change programme.
- Providing a focus on workforce activity, role design, development and education, employee relations, health and well-being and people engagement across all staff groups.
- Overseeing and contributing to the benefits realisation of workforce initiatives and processes.

Authority:
To act on behalf of the Board to receive assurances that effective arrangements are in place to oversee the delivery of the Trust's Workforce Strategy and underpinning enabling strategies and workforce programmes.

Deliverables:
Assurance to the Board will be via:

- The successful implementation of the Workforce Strategy, enabling strategies and underpinning programmes and plans.
- Effective management of risk relating to the workforce portfolio providing assurances to the Board that effective controls are in place to manage workforce risks.

- Delivery of the Trust's action plans in relation to compliance, legislative and regulatory requirements relating to workforce.
- The implementation of the requirements of the NHS People Plan and other nationally agreed guidance.
- Compliance with relevant standards and key performance indicators relating to workforce.
- Successful programmes of work/initiatives identified from feedback of staff surveys and other indicators of staff experience, including themes and trends and updates on desired outcomes.
- Feedback from other internal workforce forums.
- Progress of identified work from all standing sub-groups and delivery of any relevant programmes and plans.
- Feedback from staff Networks where appropriate.
- Ongoing progress on developing the organisational offer to support health and wellbeing programme and plans and providing assurance on the benefits of such schemes.
- Updates on the Trust Academy Programme and its contribution to the wider workforce strategy and organisational development plans.
- Progress on recommendations and actions resulting from Internal Audit outcomes relating to workforce and organisational development.

Sub Groups:

Subgroups will be developed as and when required.

Implementation date: 19 January 2022
Date of Board approval: 2 February 2022
Review Date: 19 October 2022

Reporting schedule for People Committee

	Jan Q4	April Q1	July Q2	October Q3
Deadline for papers	12 Jan 2022	13 Apr 2022	13 Jul 2022	12 Oct 2022
Meeting dates	19 Jan 2022	20 Apr 2022	20 Jul 2022	19 Oct 2022
Routine (Quarterly) Reporting				
Recruitment Assurance (including timescales, right to work checks, DBS)				
Employment Update (including turnover, vacancy rates, sickness absence, retire and return)				
Workforce Quarterly Report (to commence April 2022)				
Medical Recruitment Update				
Employee Relations				
NHS People Plan Action				
EDI Action Plan Update				
Quarterly Staff Survey Results	x			
Future Organisational Change (to commence April 2022)				
Guardian of Safe Working Hours Report				
Twice yearly Reporting				
Raising Concerns Report				
Staff Survey Actions Update				
Exit Questionnaire Report				
Workforce Risk Register				
Health and Wellbeing Update				
Staff Psychological Services Performance Report				
Training Academy Update				Includes annual report

Annual reporting				
Employee Relations Year End				
Gender Pay Gap				
Guardian of Safe Working Hours Annual Report				
Medical Revalidation				
Clinical Excellence Awards	TBC			
Workforce Race Equality Standard / Workforce Disability Equality Standard				
Equality, Diversity and Inclusion Annual Report				
Trade Union Facilities Time				
CPD Allocations				
Workforce Plans (dates may change in line with submissions)				
Committee annual assessment of effectiveness and review of terms of reference				
For Information				
Workforce Policy Update				
Workforce Internal Audits				
Workforce Focus				
Staff Survey Results				
eg, Recruitment and Retention	TBC			
eg, Organisation Development/Improvement	TBC			
eg, focus on Improving People Practices	TBC			

Report to the Board of Directors

Wednesday 2nd February 2022

Title of report	**2021 Education and Training Self-Assessment Report (SAR)**
Report author(s)	**Drs Bruce Owen, Director of Medical Education**
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	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	24/01/22
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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

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

2021 Education and Training Self-Assessment Report (SAR)
Report to the Board of Directors
2nd February 2022

1. Executive Summary

The 2021 Education and Training Self-Assessment Report (SAR) and attached Quality Improvement Plan (QIP) form an important part of the governance processes around medical and multi-professional education and training. As part of this cycle the trust in annually visited by the HEE NE&NC quality team, chaired by Prof Kumar as PG Dean. The purpose of this cycle being to quality assure the training delivered within CNTW according to the educational standards set out by the GMC and other professional bodies. At these annual visits a range of data will be triangulated to provide an overall assessment of the trust's performance, along with external local and national data this will include the trusts own self-assessment of their performance. This report outlines our assessment and is linked to a Quality Improvement Plan which outlines measures in place and planned to improve performance.

The period being assessed is the 2020/21 academic year.
The report itself starts with an executive summary (section 1) outlining the main areas of success and challenge before providing some comment on current HEE priority areas. The main bulk of the report (section 2) then covers each of the quality standards for education and training with report by exception. The final sections cover policies and processes as well as financial accountability.

For the board's orientation I have included a copy of the quality grid provided by HEE at their last visit to the trust as this provides a helpful overview of the HEE assessment of trust performance in the year immediately preceding this report. Our own assessment is that for the reporting year overall the position remains good in relation to the quality of training. Objective evidence through training surveys suggests compared to last year we have performed strongly on support provided to trainers, although feedback from trainees has dipped a little but remains good.

Particular areas of strength relate to trainer support, work on equality and a pilot we have run from student children's nurses to have MH placements. Areas of challenge are recruitment, particularly for trainers and within North Cumbria, the impact of the covid19 pandemic and changes in the Northumbria, Sunderland and Teesside placement administrative systems.

3. Risks and mitigations associated with the report

The quality assurance process of education is key for CNTW for a number of reasons, our performance as a post graduate and undergraduate education provider impacts our wider reputation as a trust. Having good quality training is also critical to recruitment, impact patient experience and ensures a regular flow of junior doctors as well as undergraduate learners, many of whom play an important part of our service provision. There are also important financial implications relating to the educational contracts we hold with partners in education

4. Recommendation/Summary

We are requesting board approval of this report, a condition of its submission to HEE.

Name of Author	Bruce Owen, Director of Medical Education
Name of Executive Lead	Rajesh Nadkarni, Executive Medical Director

NB: Appendices can be included to support Board reports, however, these should be additional documents / reading material for information only but should not be relied upon for decision

Version Control: 2019/20 Year End (at Aug 20)	HEE North East & North Cumbria Current View of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust						
GMC TRAINEE NTS 2019	**GMC TRAINER NTS 2019**	**CQC Rating**	**NHSI Segment Rating**	**CNE QSG Monitoring**	**Initial LDA HEE NE Funding provided to Trust for 2019/20**		
9/206 HEE 9/233 UK	**9/206 HEE 9/233 UK**	**OUTSTANDING G, O, O, O, O July 2018**	**1**	**ROUTINE**	**£ 7,447,710**		

	Current HEE Intensive Support Framework Escalation Levels							
	HEE Overall ISF escalation	**Domain 1 Learning Environment & Culture**	**Domain 2 Educational Governance & Leadership**	**Domain 3 Supporting & Empowering Learners**	**Domain 4 Supporting & Empowering Educators**	**Domain 5 Delivering Curricula & Assessments**	**Domain 6 Developing a Sustainable Workforce**	**Comments/Concerns**
HEE view of LEP at organisational level	**0**	**0**	**1**	**0***	**0***	**0**	**0**	**Overall:** **1:** **2: Governance of system & post changes** **3: Year on year ranking in trainee NTS** **4: Year on year ranking in trainer NTS** **5:** **6:**

System view of Service Groups	**CQC ratings of Service Groups**	**HEE ISF Escalation Levels of Training Posts & Programmes by Domain**						**Negative**	**Positive**
Adults of Working Age	**G**	**0**	**0**	**0**	**0***	**0**	**0**		
Child & Adolescent	**O**	**0**	**0**	**0**	**0***	**0**	**0**		
Community	**O**	**0**	**0**	**0**	**0***	**0**	**0**		
Older People	**G**	**0**	**0**	**0**	**0***	**0**	**0**		
Forensic	**G**	**0**	**0**	**0**	**0***	**0**	**0**		
Rehabilitation	**O**	**0**	**0**	**0**	**0***	**0**	**0**		
Learning Disability	**O**	**0**	**0**	**0**	**0***	**0**	**0**		

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

Trust Quality Improvement action Plan (QIP) 2020_2021

Organisations details:

Trust's name:	Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
Trust Chief Executive's name:	James Duncan
Director(s) of Education's name: ***(or equivalent, please state job title(s))***	Dr Bruce Owen
QIP compiled by ***(responsible for completion of)***	Drs Bruce Owen, Prathibha Rao, Lisa Insole, Rachel Gore & Frauke Boddy, Emma Paisley, Michelle Hall, Esther Cohen-Tovee, Anthony Young & Martina Khundakar
QIP signed off by:	
Date signed off:	

Trust Quality Improvement action Plan (QIP) 2020/21
Specialty, Foundation and GP

Local Education Provider	Site	Standards for medical education; Select Theme / Domain	Programme curriculum	Post Specialty	Please list the level of trainees affected	Date item was identified / added to the QIP	Initial RAG rating	Description of item (issue / concern or area for improvement)	Actions (please list planned actions)	Deadline for completion	Current Status	Current RAG	Previous Updates (collated, as required)	Autumn 2019 Update (including any updates since July 2019	Autumn/winter 2020 Update	Spring 2021 Update	September 2021 Update	January 2022 update
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	1. Learning Environment and Culture	All	All	All	Sep-13	Amber	Change to clinical services will have an impact on training and the educational experience of trainees	1. To ensure communication about planned service changes between services and med ed team is good. We have regular meetings with senior medical management where junior doctor issues are discussed and attendance at key group business meetings. 2. We have in place a system at the change of service we work with the services to set up a working group to explore the impact and opportunities for training.	Ongoing	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber	Item was first placed in the QIP in 2013 when there was significant reorganisation of services in Sunderland and South Tyneside. Once this change was complete the focus then moved to changes in Newcastle and Gateshead. Now have clarity around dates. Have had initital meetings with trainers and trainees around job plans. Initial plan in place	Rota changes have been implemented we will continue to monitor in the next 6 months. Service changes are still incomplete. Impact on training has been considered and plans are in place we will continue to monitor and hope to close this item next year. However it will be replaced by service changes in Cumbria	There have been three significant changes in rotas within the reporting year.The first and most significant is the introduction of a 24 hour rota for the Carleton clinic, this started Aug 2020 and has been monitored as is going well. From April 2021 F2 doctors will join this. The second has been the introduction of a training rota accross the NE again this has gone well. Finally there have been tweaks to two local rotas to enhance support/resorce refelcting the increased pressure brought about by the covid19 pandemic. These changes require this to remain on the QIP	The Carleton Clinic Rota was evaluated towards the end of the last rotation and evaluated well, there was a piece of work done with night coordinators to enhnce support offered to trainees and this now has foundation doctors on it and futher evaluation planned. Evaluation of the training rota ongoing. The final rota without resident 24 hour cover is for Yewdale ward in West Cumbria and we are starting work looking jointly with NCIC at how this could be addressed through a joint rota with the acute service where it is geographically located	Feedback from night coordinators has been positive. Evaluation to be done by Foundation Tutor in October. Discussions ongoing regarding West Cumbria and joint rota with NCIC. GMC survey data suggests good satisfaction with out of hours feedback in Cumbria however more broadly we will continue to monitor out of hours supervision across the Trust	[illegible] in relation to out of hours cover. There have been challenges in maintaing some of the training posts in Cumbria and this has led to new posts being devleoped, the ward where there was particular challenge, while being staffed through trust employed doctors still is covered out of hours by trainees. We review this regularly to ensure not porblems, which to date has been ok but will continue to montor. In relation to Yewdale ward we
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	6. Developing a Sustainable Workforce	All	All	All	Sep-16	Amber	The current recruitment into psychiatry for both trainees and consultants is challenging and predication of the future workforce needs suggest this will worsen, particularly in the North East. Although the risks of this are significant we have already a number of strategies in place which are working well however the magnitude of the problem requires a review of approaches.	1. Develop and implement a recruitment strategy.	Ongoing	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber	Recruitment strategy has been developed with a number of components. F3 Programme, CESR Fellowship, overseas recruitment, WAST & MTI. Working with School of Psychiatry to look at ways of retaining trainees in the region. Consultant recruitment is the biggest challenge. International recruitment showing some benefits. Remains an ongoing issue. Trying to foucs on specific areas	Futher trip to India in December for recruitment. GMC sponsorship been renewed. CESR Fellowship implemented. North Cumbria services moving to NTW is likely to make recruitment more of a challenge	Recruitment remains on our QIP due to the critical importance it plays in our service delivery and ongoing fragility. There continues to be improvements and over the reporting year core and higher training recruitment has reached a level we are happy with accross all schemes with the exception of LD higher training. Our CESR scheme is going well and we have sourced resource to expand this. We are aiming to devleop academic teaching fellow posts and continue our overseas IF post	Recruitment to core and higher trianing remains good with the exception of LD higher training. Is ongoing work with the college to look at expansion of posts as current numbers inadequate. Proposal to expand CESR scheme is being progressed as this working well. Specific strategy to look at trainer recruitment in N Cumbria	Trainee recruitment remains good with the exception of LD psychiatry. Early messages suggest we will benefit from further core trainee expansion in 2022 and we are making a case for higher trainee expansion too. Trainer recruitment remains a real challenge in Cumbria and Northumberland. Trust strategy in place to address this. Expansion of CESR programme underway	The major challenge with trainer recruitment remains in N Cumbria, there have been a number of innovative solutions devleoped with the trust working closely with the school to ensure training protected. We are also looking to expand higher training posts in North CUmbria and this something the locality is keen for. Accross the NE recruitment is much improved and we are keen to expand training posts, along with expansion of our CESR Fellowship programme and GMC Fellowship programme both of which have been recently expanded.
Northumberland, Tyne and Wear NHS Foundation Trust	St Georges Hospital Site (Morpeth)	3. Supporting and Empowering Learners	All	All	All	Jun-16	Amber	We are aware from a number of sources of feedback and evaluation that over the last 8-10 months the training experience in SGP has been less positive than elsewhere in the trust. This has significant implications for trainee experience as well as wider issues such as recruitment.	1. Increasing junior doctor resource in to inpatient services through appointment of SAS and LAS doctors. 2. Close monitoring of service quality and training opportunities through meetings with trainees. 3. Regular reviews with service management around availability of supervision and support.	Ongoing	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber	For a brief period trainees were removed from one old age ward as we could not confidently provide appropriate supervision, clinical and educational. Following reorganisation the training experience was monitored. Out of hours remains busy and is also being monitored. Remains an issue but we are comfortable with how we are managing it	Trainee posts continue to rate well there remains a problem with trainer availability on two wards so we continue to monitor. We have added 2.5 extra posts in to the site in order to manage workload and protect training time	Trainee posts continue to evaluate well with all current posts having stable clinical supervision arrangements. A ward which was closed to training due to non- availability of trainer has a trainer now, and we are in the process of phased introduction of trainees onto that ward with regular evaluation.Out of hours work intensity is being monitored closely and additional weekend capacity created within the rota.	Changes with trainers on acute wards at SGP is ongoing, requiring ongoing monitoring and adapting trainee's placements to align itself with consistent supervision and good training environments. We have implemented the guidance for monitoring when trainer provision is less than adequate, and will adapt accordingly. Local service managers made aware of these measures	Most recent GMC feedback consistent with recent improved pattern at SGP. No longer an outlier so item can be closed	
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	3. Supporting and Empowering Learners	Foundation Programme	All	Foundation	Oct-18	Amber	Balance between workload and supervision vs adequate experience with F1 trainees needs reviewing. Trainees reporting whilst good levels of supervision would benefit from additional opportunities in service delivery.	1. Foundation Trainers have been informed about GMC pink score for adequate experience and there have been discussions about how to address this. 2. Regular meetings with Foundation Trainees will specifically explore this issue to further clarify need.	Oct-19	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber	Discussion has been had with trainers and forum has been set up later this year to discuss further	Work done with F1s has improved GMC survey feedback. However, feedback from F2s is a negative outlier for curriculum coverage, exploration of this relates to practical procedures. A plan is in place to raise awareness with trainees of the common practical procedures they can gain competentices in within psychiatry, this is a separate QIP item	Is discussed at induction that psychiatry experiences are different but can still be linked to core procedures and examples given. F1s will gain experience during on call work. Asked to bring up at mid terms or discuss with supervisor. No concerns noted at this point.	No concerns noted following mid term reviews with trainees		Following recent interventions recent GMC survey showing no issues. Item closed
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	3. Supporting and Empowering Learners	Core Psychiatry Training, General Practice	All	Core, GP	Oct-18	Amber	Discussions with trainees have highlighted unnecessarily high levels of trainee time spent reviewing routine monitoring investigations with little educational value.	1. Have met with modern matron and 2 trainee reps to look at solutions to the problem. 2. Initial change in process described and will look to pilot this if successful to expand across the Trust.	Oct-19	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber	Ongoing piece of work, system being described and due to be piloted	System described has been implemented in the North following pilot. Ongoing issue in the South, ongoing piece of work to implement this across the Trust	The implementation of process around management of review of routine investigations within community services has been agreed. Is however need to get feedback from trainees to ensure this translated into change in practice prior to closing this action off.	Process working well in the North. ECG reporting system is done by an external company. Physical treatment team does all inputting of information on to RiO. Trainees respond to abnormal results only and will communicate anything necessary to GPs. Still a challenge in the South - time needed to trial new way of working and capacity of staff an issue	Remains a challenge in the South ongoing discussions with services about how to address it	Planning to meet with service managers to explore best practice from other CTTs
Northumberland, Tyne and Wear NHS Foundation Trust	Tranwell Unit	3. Supporting and Empowering Learners	General Practice, Foundation Programme	General psychiatry	GP	Jun-19	Amber	Trainer availability had adverse impact on trainee experience in a specific ward at the Tranwell unit	GP and Foundation tutor meet with trainee and identify details and share with med ed team. Once nature of problem clarified to develop plan to address	Aug-19	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber		Investigation identified that significant shortfall in supervision, initial attempts to look at alternative local arrangements were not succesful and hence posts were reviewed and trainees not currently working into the ward until additional trainer resource available	Training experience has now improved on one of the wards (Fellside) and original trainee composition restored successfully with regular evaluation systems in place to monitor. Following retirement of trainer on a different ward (Lamesley), the training experience is now being monitored very closely. We have appointed additional trust doctor to support the trainees. So far no obvious concerns in relation to supervision or safety reported.	Fellside ward changes have now been embedded successfully and this can be closed. The situation on the adjoining ward, Lamesley was being monitored closely, but now likely to be closed in the next few months, after appointment of substantial consultant into the role, who is keen to take on trainer responsibilities. This item is likely to be closed in the next QIP review	Situation has improved. Will continue to monitor	No further issues. Item closed
Northumberland, Tyne and Wear NHS Foundation Trust	St Nicholas Hospital (Newcastle Upon Tyne)	1. Learning Environment and Culture	All	All	All	Jun-19	Red	Accommodation to support delivery of medical education in central patch of trust inadequate in both quality and capacity	link with Estates to identify options having clarified criteria. Once this done to present to board and exec team	Oct-19	Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber		Plans been drawn up for suitable accomodation . Board discussion occurred in october board and subsequent discussion with CEO. Plan to present to execs Nov	Has been positive progress with this action in that funding agreed, site identified that meets our needs and is currently at stage of bids being asked from contractors woith goal of completing work by Aug 2021 in line with need. Once completed can close off this action	Work has started and is progressing well. Completion date is end of August 21	Delayed until mid October due to materials shortage	Complete item closed

Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	3. Supporting and Empowering Learners	Core Psychiatry Training	All	Core	Sep-19	Amber	Availability of long case psychotherapy for core trainees raised as problem by trainee rep	AMD PG to meet with psychotherpay tutor to explore this and feedback	Oct-19	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber		Following meeting issue explored and current process felt to be working well. Review to look for cases where trainees had not been able to access cases suggested working well. Agreed would monitor and systematically record length of time to have case identified to ensure not problem	Situation with access to appropriate cases, waiting times and access to supervision was affected further due to the COVID pandemic and initial restrictions with face to face interviews. This was seen as a potential threat to acheiving ARCP outcomes within appropriate timeframes and potential to extend training periods for a few trainees. While some trainees had to seek COVID ARCP outcomes, we managed to support most trainees with resuming their psychotherapy training as soon as possible and exploring IT solutions when possible . Increased core training recruitment in 2020 has also posed some additional challenges with a need to review our capacity to support psychotherapy training.We have now tripled our capacity for Balint sessions. Short case- capacity for induction, case and supervision is now resolved with increased funding provision. Long case capacity is now being looked into, and appears to be resolving with recruitment of additional Consultant in Psychotherapy and some additional capacity for supervision from exisiting Psyhcotherapy supervisor from Cumbria. We have organised regular meetings with the Psychotherapy tutor and AMD to address problems in a timely manner.	While a few trainees had to avail COVID ARCP outcomes for completion of psychotherapy competencies, they are all on track and likely to complete these within reasonable time frames. We coped with the increased bulge in intake in 2020 in terms of psychotherapy training for the 1st year. Plans in place to explore resources required for ongoing training requirements for this batch-discussions with DME and services underway and outcomes looking positive and achievable. This will need ongoing monitoring and regular planned meetings with AMD and psychotherapy tutor to address and review this	Covid pressure has eased and additional capacity being resourced for the future to ensure supervision can be provided	Funding is secured for additional supervision time. Person planned to be seconded not available, service looking for replacement
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	5. Delivering Curricula and Assessments	Core Psychiatry Training	All	Core	Jun-20	Amber	CBT short case supervisor capacity, due to increasing trainee numbers and service changes the capacity for supervising CBT training was below the demand which creates a risk of trainees not being able to access short case supervision, a curriculum recquirement.	Working alongside clinical services a business case was developped to fund additional CBT therapist time, this post would provide 0.6 WTE for training with additional clinical time provided by the service. This has had funding approval and is currently out to advert	Aug-21	Stage 3a: Progress not yet apparent – there is no change as of yet, but there continuing monitoring and evaluation of actions.	Green			Business plan accepted post out to advert	There are now 17 trainees who are in the process of taking on CBT cases- which will cover the majority of the new intake. There are no issues reported from the CBT centre in relation to trainer capacity and IT solutions appeared to have worked well for supervision access	Recent problems have emerged with CBT course these are being explored with Psychotherapy Team. Supervision capacity for short cases remains secure	Item closed
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	3. Supporting and Empowering Learners	All	All	All	May-20	Red	The covid19 pandemic had the potential to significantly impact training opportunities as well as disrupt supervision. Factors include impact of social restrictions on teaching, impact of work pressures on time and impact of shielding and work pressures on supervisors	Working alongside trainees and trainers we both devleoped remote ways to deliver CPD, and where needed supervison. We increased resource to support trainees and trainers and set up clear and frequent support and monitoring systems	Ongoing	Stage 3b: Monitoring Progress – Actions are being implemented, and there is evidence of improvement through monitoring.	Amber			We have used experience from the COVID impact during the 1st phase in informing our trainers to have individual discussions with trainees in relation to work adjustments should there be a similar situation in the future. Plans to support trainers with IT solutions is currently underway. We will monitor this with regular quality assurance mechanisms.	Initial discussions with trainees identified specific issues in relation to psychotherapy delivery impacted by covid and plan to address this through additional sessional time for supervisors. In addition to this IT access for speciality trainees being addressed and will be laptops for each core trainee from Aug. Further review of other outstanding training impact being devleoped with TLiC	Implemented provision of laptops to all Core Trainees. Postgraduate teaching attendance is good. Regional teaching is running	Item closed
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	1. Learning Environment and Culture	All	All	All	May-21	Red	Feedback from trainees has identified that for a number of trainees have experienced discrimination while at work. This has been in clinical and team settings	This information has been shared within the trust and will inform wider trust work to reduce discrimination. In addition to this we are developing some specific measures to both support trainees and trainers in managing discrimination and accessing support.	Initial work with trainers and trainees to be devleoped and implemented within 2021. Evaluation of this over 12 month period. Aiming to do this jointy with colleagues from HEE NE and NC and Ncl Univesity	Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber					Resources being developed to support training and education around discrimination for trainees and trainers. Plan to implement and evaluate over this academic year	Trainees training programme has been developed, first session has taken place, evaluation ongoing. Session at meded conference for trainers. Wider work continuing
Northumberland, Tyne and Wear NHS Foundation Trust		6. Developing a Sustainable Workforce	All	All	All	May-21	Red	Due to retire and return, resignations and clinicians taking up new posts, the provision of clinical supervision has become unstable. Several posts have been overseen by clinicians that don't work in the placement and trainees supervised clinically by other consultants and SAS doctors. Some of the training posts in Carlisle and Whitehaven have been identified as unviable from August 2021 due to the lack of consultants and SAS doctors in inpatient and outpatient settings to support junior doctors	Contingencies being put in place at this time. Doctors to be approached to take on supervision roles and tasks. Additional supervisors in the medium to long term being discussed	Ongoing	Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber				2 new Consultant appointments but remains very tight. Have been able to increase number of Core Trainees and have plan to further increase in February. Trainer capacity remains a hot issue	As noted above under trainee recruiment, this remains a significant challenge and the acuity of this led to a number of training posts been reviewed and re-developed. Imortantly these remained in N Cumbria and we are hoping to expand higher training posts in the region. The situation remains fragile however due to the low number of substantive consltants in post
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	3. Supporting and Empowering Learners	All	All	All	Sep-21	Amber	The 2021 GMC trainee survey has shown a reduced score for the trust in Educational Supervision. We are concious that there has over the last year or so been a change in the way educational supervisors are recruited and this has led us to consider if we need to look at additional support for them	We are planning to offer a workshop within our med ed onference focussed specifically at the roleof Ed Supervisors and pick up through appraisal further feedback about how supervisors are finding the role	Ongoing								
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	5. Delivering Curricula and Assessments	Core Psychiatry Training	All	Core	Dec-21	Amber	The GMC 2021 trainee survey has indicated that further imrpovement can be made in offering core practical experiences and learning experiences within posts	We plan to raise this within the Tlic group to help design a short project to explore how this can be improved.One suggestion may be to look at reciting physicians associate support to offer meore mental health related experience. We will review this as a standing item within college tutor reviews and offer feedback to trainees.	Ongoing								
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	5. Delivering Curricula and Assessments	General psychiatry	All	Higher	Dec-21	Amber	The GMC 2021 trainee survey suggests that professional training experience will need to improve	There is a plan to involve higher trainees in more formal medical student teaching with support from Associate Dean for Undergraduate studies in Newcastle. There is already a be-spoke Quality improvement training package that has commenced with good feedback. We have restarted the higher trainee residential event after the hiatus of the pandemic- which covers the research, leadership and management opportunities.	Ongoing								

Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	1. Learning Environment and Culture	Child and adolescent psychiatry	All	Higher	Dec-21	Amber	GMC 2021 survey indicates that while some aspects of induction is met, due to the out of sync rotation commencement of the CAMHS higher trainees- the induction is not as robust as compared to other trainees	We will plan to include a mix of recorded mandatory induction resources along with specialty specific induction that will include trainee delivered OOH rota sessions and SIM sessions and review with feedback

Trust Quality Improvement action Plan (QIP) 2020/21
Multiprofessional

Local Education Provider	Site	HEE Quality Framework Domains	Profession	Service Area	Please list the level of learners affected	Date item was identified / added to the QIP	Initial RAG rating	Description of item (issue / concern or area for improvement)	Actions (please list planned actions)	Deadline for completion	Current Status	Current RAG	Previous Updates (collated, as required)	Autumn 2019 Update (including any updates since July 2019	Autumn/winter 2020 Update	Column1
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	6. Developing a Sustainable Workforce	Pharmacists	Pharmacy services	Pre-Registration	09.12.20	Amber	Risk of removal of salary replacement costs for pre-registration pharmacists will disappear and could threaten the sustainability of the pharmacy workforce.	CNTW pharmacy currently partake in multiple regional placements and are actively involved in discussions with relevant groups at regional levels to look at future funding workstreams.	Ongoing	Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber				
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	6. Developing a Sustainable Workforce	Pharmacists	Pharmacy services	Pre-Registration	09.12.20	Amber	Development of future integrated pre-registration training withing undergraduate pharmacy course and how mental health will be embedded in such a scheme.	CNTW is involved within regional groups which will address this and the department also has links with the relevant higher educational institutes/local schools of pharmacy	Ongoing	Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber				
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide, Trust-wide	6. Developing a Sustainable Workforce	Learning Disabilities Nursing		Pre-Registration			maintenance and expansion of learning disability nursing workforce	We have seen a gradual increase in the numbers accessing local undergraduate learning disability programmes and this is welcomed. However there remains a significant challenge around the learning disability workforce and ensuring this continues to exist. This requires greater access to Learning Disability nursing by having adequate Learning Disability nurses trained to support the workforce need across mental health, primary care and acute services across the region			Red			Regional work commenced however with covid 19 requires fruther work key is ensuring workforce for acute and primarycare services. Recent funding has been made avaialbel to TEWV and CNTW to begin work to expand Learning Disability placement capacity internally	
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	5. Delivering Curricula and Assessments	Learning Disabilities Nursing, Mental Health Nursing, Other apprentice		Apprenticeship, BSc			delivery of clinical placements based on academic calendars creates pressure on clinical services due to significant numbers requiring placement at same time	The current implementation of on line theoretical modules offers an opportunity to work in partnership with HEI to review and establish greater flexibility in delivering of clinical placements and one which we need to further explore							
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	5. Delivering Curricula and Assessments	Learning Disabilities Nursing, Mental Health Nursing, Other apprentice		Pre-Registration			Development and delivery of shared ARCP	further clarification is needed on the process for allocation of placements and consideration needs to be given to the need to move focus from academic calendars to create greater flexibility in delivery of clinical placements							
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	1. Learning Environment and Culture, 3. Supporting and Empowering Learners	Other therapist (Art, Drama, Music, etc.)	Therapy Services	Pre-Registration, Post-Registration	Jan-21	Amber	Issues with recording therapy sessions when delivered remotely. Recordings required for supervision and evaluation	Seek an IT solution with CNTW informatics	Ongoing	Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber				IAPT - High Intensity Training

Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	5. Delivering Curricula and Assessments	Occupational Therapy, Physiotherapy	Therapy Services	Pre-Registration	Jan-21	Amber	To support service user/carers to engage in the selection /interview process for AHP students and to have service user/carers deliver some of the teaching programme	Reaching out to Northumbria University	Ongoing	Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber				
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide		Pharmacists	Pharmacy services	Pre-Registration	07.01.22	Amber	The one-year foundation training year for pharmacists replaced the previous preregistration year from July 2021. Foundation training year will be embedded into the pharmacy undergraduate course in the future, how will Mental Health be embedded into this?	Links already established with local schools of pharmacy and CNTW pharmacy dept are involved in the regional trainee pharmacist advisory group/HEE		Stage 1: Investigation - Verification of concern is being undertaken and action plan is not yet in place.	Amber			Meeting to take place with Newcastle university in feb 2022 to discuss this and any other issues and also looking to increase research footprint with the university	

Trust Quality Improvement action Plan (QIP) 2020/21
Dental

Local Education Provider	Site	Standards: Select Theme (as appropriate, or describe within description of issue/cocnern)	Programme curriculum	Post Specialty	Please list the level of trainees affected	Date item was identified / added to the QIP	Initial RAG rating	Description of item (issue / concern or area for improvement)	Actions (please list planned actions)	Deadline for completion	Current Status	Current RAG	Previous Updates (collated, as required)	Autumn 2019 Update (including any updates since July 2019	Autumn/winter 2020 Update
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											
			Dentistry	Dentistry											

Trust Quality Improvement action Plan (QIP) 2020/21
Undergraduate

Local Education Provider	Site	Standards for medical education; Select Theme	Placement / Rotation (Please select all OR an option from the post specialty list. Where an issue/concern impacts on an entire rotation please ensure that this is described in the description, column G)	Date item was identified / added to the QIP	Initial RAG rating	Description of item (issue / concern or area for improvement)	Actions (please list planned actions)	Deadline for completion	Current Status	Current RAG	Previous Updates (collated, as required)	Autumn 2019 Update (including any updates since July 2019	Autumn/winter 2020 Update	Spring 2021 Update	September 2021 Update	January 2022 Update
Northumberland, Tyne and Wear NHS Foundation Trust, Northumberland, Tyne and Wear NHS Foundation Trust, Northumberland, Tyne and Wear NHS Foundation Trust, Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	1. Learning Environment and Culture	all	24/09/2019	Amber	R1.9 Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision. Student satisfaction feedback identifies that this is an issue mostly in the Tyne base unit. Students are asking for their clinical activities and supervision to be more tailored to their stage. The fifth year students for example would like more repsonsibilites in line with an assistantship model. Whilst the feedback identifies this as an isuse mainly in Tyne , we will aim to address this across the trust.	1. Review the information for clincial supervisors of medical students of different stages. Develop guidance to include information about the stage, aids to guide the supervisor to identify suitable learning activities/ clinical tasks and their level of supervision; 2. introduce this across the trust	01/12/2019		Amber		Base unit leads providing clinicians with up-to-date information about their students individually and in the PG teaching programme; the trust have added an UG update session in the faculty development programme. Feedback has improved	Upated guidance (including ideas for activities to help students meet competitencies) has been issued to clincians, student feedback still highlights not always given tasks appropriate to their learning needs- obviously also afffected by COVID - working group has been estabilised to develop multi-pronged action plan to imprive clincal placments, due to meet in January.	Working group have met and devised a plan. Personal 1-1 engagement with teams on the ground by BULs. UG update meetings. PG teaching events. Attending junior doctors induction and PG teaching. Moving to assistantships and equiping faculty and meeting student needs. Review more formally after assistantships	Feedback has improved following measures introduced, however level of supervision remains closely linked to teacher/trainer recruitment which remains a challenge in Northumberland. Additional measures have included BULs attending consultant meetings to raise the profile. As planned to review following assistantships	Assistantship has been successfully implemented where students have been integrated into a team within a 3 week placement. Teacher trainer recruitment remains an issue in Northumbria with some areas also not having designated consultant meetings, this adds to the difficulty. There are ongoing issues with staff shortages and work pressures due to the Covid 19 pandemic.
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide	1. Learning Environment and Culture	all	Jan-19	Amber	R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support. There are sigificant issues wit hthe teaching spaces at SNH which are used for both Northumbria and Tyne students: Jubilee Theatre is only space for large group teaching and is too cold. small group teaching is delivered in Keswick House- an old psychiatric ward, the rooms are too small and lack powerpoint facilites, they are also too cold, the move to a new currciulum and the advent of Sunderland medical students increase pressure on teaching spaces.	Becky Dioh and Karen Peverell completing business case for new and improved teaching spaces; bringing this before the CDT-business meeting/group			Amber		Been discussed at Board and with Chief Exec agreed as a priorty. Partial funding identified due to be further discussed with Execs in November and awaiting costs from Estates. Temporary solutions being explored for the interim period	Plans have been reviewed by the team and some changes made to proposed teaching and office spaces - project to be completed by summer 2021 - in interim Jubilee Theatre at SNH is being used for PPE storage- additional teaching spaces at Keswick House have been identified and two porta kabins have been placed to accommodate the teaching needs at SNH and provide COVID-secure teaching spaces for staff and students. since December teaching spaces have moved again to make way for the trust's vaccination centre and we are using administrative spaces for the time being.	Work has started on new teaching centre at SNH and is due to be completed by end of Aug 21. Currently looking at increased numbers of students in Sunderland and room capacity	Ongoing business case around increased students in Sunderland	Education Centre opened in November 2021 with state of the art simulation centre. However, ongoing impact of pandemic limits its use to full capacity due to social distancing measures. Ongoing business care around the commencement of Sunderland medical students in September 2022.
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide		all	2019	Amber	R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans. Specified roles, such as base unit lead or SSC lead have dedicated medical education programmed activities; clinical teachers without specific roles are expected to utilise their SPA/clinical time	1. review of "SIFT"/ student tariff money flow into services; set up meetings with business units to discuss use of student tariffs to support teaching/ teachers 2. survey of clinical teachers 3. discuss with lead for job planning	Feb-20		Amber		Meetings with Central CBU and pilot for a part "SIFT"-funded GP trainee post with UG educational component	We have reviewed the student tariff allocations for the last academic year; we have a plan to add this as an agenda item at the MSC; plan for formal review of pilot post in South of Tyne to understand implications for funding streams before developing this item further.	Planning meetings to decide on how to use Sunderland student tariffs by possibly developing UG lecturer posts and reviewing if model could be used by Newcastle	Discussions around streams of funding use in relation to Sunderland continue, initial feedback from services of proposed model has been positive	Newcastle University - there are ongoing discussions with the Trust finance team looking aligning funds with quality of teaching activity. Sunderland University - progress with ongoing discussions around business plan and how to successfully implement elements of the project management plan.
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide			06-Oct-20	Amber	Newcastle Medical School are going to move from a base unit model to an LEP-provider model; this will include moving administrative functions from the base unit offices to LEPs and will require close working with the university for a smooth transition. It might also require more administrative support. It should allow the trust more flexibilty when organising clincal timetables	Attend relevant meetings and update UG MedEd team. First meeting 7 October 2020			Amber			Ongoing . We continue to attend relevant LEP meetings and clarify the new model; establish implications for the medical education department/ structures and adapt these as necessary.	Appointed LEP Lead and will be appointing an admin lead and continue to engage with process as it is established	Admin lead has been appointed. Item now closed	
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide				Amber	Newcastle Medical School 2017 MBBS curriculum asks trusts to move to a year five assistantship in mental health.	Establish working group to develop year 5 assistantships for autumn 2021. Engagement with clincians about the bew model to secure placements for autumn 2021. Link with actions points to improve clincal placements overall. Link with course director and PIIG to contribute to curriculum development for autumn 2021 and be up to date re curriculum requirement			Amber			liaison with course director and PIIG established and on-going. Working group established and will be active from January 2021. Placements need to be agreed by July 2021.	Running specific faculty development sessions to engage clinical faculty. Regular planning meetings to establish student timetables. In process of developing formal teaching resources, reviewing induction. Challenge is making sure it's delivered in the right way	Assistantships to start in Tyne & Northumberland base units w/c 13th September. Will evaluate success of planning based on feedback	Fifth year assistantship for Newcastle University successfully implementated and an evaluation has been undertaken with recommendations for the next academic year. Item now closed.
Northumberland, Tyne and Wear NHS Foundation Trust	Trust-wide			08/06/2021	Amber	Delivery of curriculum to year 4 Sunderland medical students from September 2022. Need to be able to deliver formal and clinical teaching in to key roles	Planning meeting to decide on structure. Planned recruitment								Ongoing planning around model of delivery, business case and funding	Ongoing planning around model of delivery, business case and funding. Development of project management plan. To help with planning and implementation for September 2022.

VALIDATION
GMC Themes
All
1. Learning environment and culture
2. Educational governance
3. Supporting learners
4. Supporting educators
5. Developing and delivering curricula and assessment
Bullying and undermining

VALIDATION
RAG
Red
Amber
Green

VALIDATION
Status
Stage 1: Investigation - Verification of concern is b
Stage 2: Implementing Solutions – Action plans/pla
Stage 3a: Progress not yet apparent – there is no c
Stage 3b: Monitoring Progress – Actions are being
Stage 3c: Concerns over Progress - The action plan
Stage 4: Closed – Solutions are verified, evidence that there has been sustained improvement over an appropriate time period.

VALIDATION
Agree, strength
Agree, good practice worthy of sharin
Agree, good practice worthy of sharin
Agree, concern and known to the Sch
Agree, concern but new / not known t
Agree, concern and concerns over progress

VALIDATION
Run through
Higher
Core
GP
Foundation

VALIDATION
GMC Themes
All
1. Learning environment and culture
2. Educational governance and Leadership
3. Supporting learners
4. Supporting trainers
5. Developing and implementing curricula and assessments
6. Developing a sustainable workforce
Patient Safety
Bullying and undermining

VALIDATION
Item Selection
Strength
Good Practice
Concern

VALIDATION
Met, and exceeds in all areas
Met
Partially Met
Not Met

VALIDATION
All
Run through
Higher
Core
GP
Foundation

VALIDATION
HEE Domains
All
1. Learning Environment and Culture
2. Educational Governance and Leadership
3. Supporting and Empowering Learners
4. Supporting and Empowering Educators
5. Delivering Curricula and Assessments
6. Developing a Sustainable Workforce
Patient Safety
Bullying and undermining
LEPs
N/A
Deanery-Wide
Specialty-Wide
Unknown
County Durham and Darlington NHS Foundation Trust
Gateshead Health NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Northumberland Care Trust
Northumbria Healthcare NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust

VALIDATION Profession
Adult Nursing
Child Nursing
Clinical Psychology
Community Nursing
Dental Hygienists and Therapists
Dental Nurses
Dental technicians
Dentists
Dieticians
Estates (i.e. Clinical Engineers)
HCS – Clinical Bioinformatics
HCS – Life – Blood
HCS – Life – Cellular
HCS – Life – Genetic
HCS – Life – Infection
HCS – Physical – Clin Eng
HCS – Physical – Med Phys
HCS – Physiolog – CVRS
HCS – Physiolog – GI & Uro
HCS – Physiolog – Neuro
Health Care Scientist (HCS)
Health Visitors
Learning Disabilities Nursing
Mental Health Nursing
Midwifery

VALIDATION
All programmes within dept.
All
N/A
Academic
Acute Medicine
Adult mental health
Allergy
Anaesthetics/Theatres/Recovery
Audio vestibular
Cardiology
Cardio-thoracic surgery
Chemical pathology
Child and adolescent mental health
Child Mental Health
Clinical genetics
Clinical neurophysiology
Clinical oncology
Clinical pharmacology and therapeutics
Clinical radiology
Community Child Health
Community Sexual and Reproductive Health
Dermatology
Diagnostic neuropathology
Elderly Care medicine
Emergency Medicine

Validation Level
Apprenticeship
Band 1-4
BSc
CWD
MSc
Other
PhD
Post-Registration
Pre-Registration

Validation Service Area
Cancer care
Community Health
Dental
Dietetics and nutrition
Emergency Department
Genetics
Laboratory Medicine
Maternity services
Medical
Musculoskeletal services
Neurosciences
Older People services
Ophthalmology
Pharmacy services
Radiology
Rehabilitation
Sexual and Reproductive Health
Surgical
Theatres and Anaesthetics
Therapy Services

South Tyneside and Sunderland NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Nursing Associate
Occupational Therapy
ODP
Ophthalmologists
Orthoptists
Orthotists and Prosthetists
Other apprentice
Other therapist (Art, Drama, Music, etc.)
Paramedics
Pharmacists
Pharmacy Technicians
Physiotherapy
Podiatry
Radiography Diagnostic
Radiography Therapeutics
Sexual Health Advisor
Sonographers
Speech and Language Therapy

Endocrinology and diabetes mellitus
Forensic histopathology
Forensic Pathology
Forensic psychiatry
Gastroenterology
General medicine
General surgery
Genito-urinary medicine
Gynaecological Oncology
Haematology
Hepatology
Histopathology
Immunology
Infectious diseases
Intensive care medicine
Interventional Radiology
Liaison Psychiatry
Maternal and Fetal Medicine
Microbiology
Oncology
Psychotherapy
Virology
Metabolic Medicine
Neonatal Medicine
Neurology
Neuropathology
Neurosurgery
Nuclear medicine
Obstetrics and gynaecology
Occupational health
Older Persons Mental health
Ophthalmology
Oral and maxillo-facial surgery
Otolaryngology
Paediatric and perinatal pathology
Paediatric cardiology
Paediatric Clinical Pharmacology and Therapeutics
Paediatric Diabetes and Endocrinology
Paediatric Emergency Medicine
Paediatric Emergency Medicine
Paediatric Gastroenterology, Hepatology and Nutrition
Paediatric Immunology, Infectious Diseases and Allergy
Paediatric Inherited Metabolic Medicine
Paediatric Intensive Care Medicine
Paediatric Nephrology
Paediatric Neurodisability
Paediatric Neurology
Paediatric Oncology
Paediatric Palliative Medicine
Paediatric Pathology
Paediatric Respiratory Medicine
Paediatric Rheumatology
Paediatric surgery

Paediatrics
Palliative medicine
Pharmaceuticals
Plastic surgery
Learning disability
Public health
Rehabilitation general
Rehabilitation mental health
Renal medicine
Reproductive Medicine
Respirology
Rheumatology
Sexual and Reproductive Health
Sport and exercise medicine
Stroke
Substance Misuse Psychiatry
Trauma and orthopaedic surgery
Tropical medicine
Urogynaecology
Urology
Vascular surgery

Health Education England

2021 Education & Training Self-Assessment Report (SAR)

Reporting Period: 1 August 2020 to 31 July 2021

Deadline for submission to HEE NE: 31 January 2022

Trust's name:	**Cumbria, Northumberland Tyne and Wear NHS Foundation Trust**
Trust Chief Executive's name:	**James Duncan**
Value of contract / funding with HEE:	Total initial 21/22 Education Contract value Q2 Indicative: £10,687,332.00
Director(s) / those responsible for Education (name and role):	**Dr Bruce Owen, Director of Medical Education** **Anne Moore, Group Nurse Director**
Name and Title of author(s):	**Drs Bruce Owen, Prathibha Rao, Martina Esisi, Nicola Phillips. Emma Paisley, Anne Moore, Michelle Hall, Louise Wicks, Anthony Young, Martina Khundakar and Esther Cohen-Tovee**
Report signed off by:	**James and Rajesh to sign here**  **Dr Rajesh Nadkarni** **Executive Medical Director**
Name of Board Level Exec/Non-exec Director responsible for Education and Training: **Board Approval Status and Date:**	**Dr Rajesh Nadkarni, Executive Medical Director** Due at Board 02/02/2022

The SAR is aligned to the GMC Standards for medical education: Promoting excellence, and the HEE standards which includes a sixth theme, developing a Sustainable Workforce. The SAR should be read alongside the relevant Quality Improvement Plan (QIP).

Contents

Section 1: Executive Summary

1.1 Organisation's governance for education and training

To help outline your organisation and team, please briefly describe current structures. Please share visuals.to demonstrate multi-professional education structures, reporting to the Trust Board. This will also help ensure we maintain up to date key contacts.

Within CNTW there are established educational teams leading on the delivery and quality management of both medical and multi-professional training. These teams report up within the trust through CDT (Corporate Decision Team) which the medical and multi-professional educational leads both have a seat on, and then onto the trust board, where educational agenda items feature regularly.

Within the medical education team the team manager and quality lead work alongside the DME and AMDs within medical education to review quality metrics and priorities. These are then shared with both the executive team and trust board. Following the mental health services from North Cumbria joining the trust local educational and governance structures and policies were reviewed aligning practices across the whole trust, these systems are working well.

Within the multi-professional education structure, there are similar structures with dedicated teams planning education and placements and linking into the executive team and trust board.

Attached are organisational diagrams outlining these structures and links.

1.2 Top three education and training successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period. Please list any successes/good practice items that you would like to highlight to HEE. These may include trust wide initiatives as well as departmental / unit examples. Any items listed here will be uploaded to HEEs Good Practice System for sharing across the region.

	Top three education and training successes		
	1	2	3
What was implemented and why?	Training on discrimination in response to feedback locally and nationally about the prevalence of NHS staff facing discrimination	Delivery of Faculty Development Programme	Pilot study for children's student nurses to have a placement in mental health children's services. This was very well received and plans are underway to make this a permanent placement for children's student nurses.
Profession(s) it relates to	Initial focus on medical staff goal to expand across all staff within CNTW and resources have been made available across HEE NE&NC	Medical Postgraduate trainers	Children's mental health nursing

HEE domain(s) and standard(s) it relates to	Domain 1, standard 1.2 and 1.6	Domain 4	Domain 1 and 3
Benefits or positive impact?	Ongoing evaluation of benefits, initial feedback suggest benefit learning outcomes achieved around increasing knowledge and awareness of discrimination as well as how to respond to discrimination and awareness of supports available	Feedback from trainers in relation to sense of support around training role, knowledge and training in PG and UG education all suggest trainers valued the training programme and this supported their ability to train and deliver UG education to learners	Promotes an understanding of mental health services and develops children's nurses knowledge, skills and awareness of mental health throughout the physical health pathway
Lessons learned and difficulties encountered	Ongoing evaluation, initial experience highlighted that nature of training makes importance of planning timing and promotion of training particularly important to maximise attendance.	Covid19 pandemic created challenges around delivery of training for trainers, however use of remote learning approaches worked well. Developing techniques with adaptions including more use of simulated scenarios and use of small groups allowed good attendance and engagement despite challenge	Children's nurses need a more thorough induction and continued support as they are unfamiliar with mental health
Contact for further information (name, role, email, telephone number)	Drs Bruce Owen, Prathibha Rao, Lachlan Fotheringham, Okaimama Okayhirome and Joe Thorne	Leona Fairhurst, Karen Peverell	Amy.bradley@cntw.nhs.uk

Please add these and any additional items that you would like to share with the region to the 'Good Practice System' here

1.3 Top three education and training challenges or prominent issues

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
1. Recruitment of trainers and clinical staff,	6	

2021 RCPsych data from a national census has highlighted an increasing problem with the recruitment of psychiatrists; data shows only 76% of consultant and 70% SAS doctor posts are currently filled nationally. This places significant pressure on both training and service capacity. Within CNTW we have developed a range of recruitment strategies including use of overseas recruitment, a CESR Fellowship programme (recently expanded from 5 to 10 Fellows, programme now 2.5 years in and 1 doctor successfully completed with 2 more expected within the year) and innovative new roles including the medical assistant role (following pilot additional 12 posts recruited to last year). These strategies have helped us keep our overall vacancy rates below the national average however there is considerable variation across sites with N Cumbria being most challenging. Despite this through innovate approaches we have been able to expand our number of training posts in North Cumbria and establish a 24 hour first on call rota, the situation remains fragile and this remains a significant challenge.		
2. Covid19 Pandemic For CNTW, as for all LEPs the ongoing covid19 pandemic has created significant challenges in relation to UG and PG education. Pressures on clinical services, the impact of IPC measures of training and the impact of illness on staff have all created significant challenge. We have however been able to adapt delivery of training to meet the restrictions and minimise the impact. There have also been some positives through increase familiarity with remote communication and streamlined processes for change. Clinical placements for nursing and AHP are also challenge within the current restrictions posed by COVID. Creative ways of providing nursing/AHP education have been crucial to continuing their clinical education. Details of measures to adapt to this situation are outlined in section 1.4 below	1, 3	
3. Northumbria, Sunderland and Teesside Universities have recently adopted a 'joint ARCPEP' student placement administration system. This is a positive move however, teething problems are expected. There are IT teams in place to respond appropriately.		

1.4 HEE NENC priority themes for 2021-22 quality cycle

HEE NENC has identified priority themes from issues arising over the previous Quality Cycle(s) and is keen to identify how your organisation is adapting and planning to address these, with a view to ensuring the continued delivery of high quality education and training across all programmes and placements within your organisation.

HEE NENC's priorities are identified for each domain of the HEE Quality Framework. Please complete each section identifying how your organisation is addressing each theme across all programmes and placements, which areas and issues are proving to be the greatest challenge, and what additional support would be helpful in addressing these.

Due to the difference in reporting responsibility to the GMC, we have provided a separate section to capture a specific medical response. Mindful of time and in a bid to ensure proportionality, please write a concise overall summary.

HEE priority themes for 2021-22 quality cycle

Domain 1 Learning environment and culture

- Please describe the impact of Covid-19 on the clinical learning environment and in particular on teamworking and mutual support.
- Please describe your Equality, Diversity and Inclusion strategies and initiatives and how you measure their impact.

Multi-professional:

Nursing

Maintaining clinical services and patient/staff safety is top priority and business continuity is constantly being reviewed by Gold Command.
Remote working is in place for staff who don't need to be on NHS premises to promote safety.
Rotas are in place to monitor the amount of staff/students in clinical/non clinical environments in order maintain a safe work place/educational environment.
All staff/students have a risk assessment.
There is an increased frequency of team meetings to promote team working and support. Teams have adopted a culture of 'checking in' with each other.
The Trust has bought lap tops to loan to nursing and AHP students so they can still have a valuable, educational clinical placement. They join in with clinicians and everyday clinical activities remotely.
Significant resources are dedicated to staff wellbeing, for example the staff well-being service, AWISH, yoga, Schwartz rounds, leisure activities and so on.
The trust has a clear policy and lead for equality and diversity. The trusts lead for equality and diversity has delivered training to students as well as staff. Metric 3004 is a CNTW training metric that measures the concordance with numbers of staff attending an introduction to equality and diversity. The trust is well above the standard of 85%.
The trust collects regular feedback in the friends and family test, points of you and the staff survey. The feedback is good and staff/service user and carer feedback is proactively sought.
The Nurse education forum was stood down during the height of the pandemic but has recently restarted. This is a trustwide forum for sharing good practice, ideas and innovations.

Pharmacy

We have continued to maintain a safe clinical learning environment for both undergraduate pharmacy students placements and also for pre-registration trainees during 2021/2022 despite working in a Covid secure manner and during the restrictions ongoing in the pandemic. There still remains a structured and comprehensive induction for all our new staff who have started in our department. Full attendance has occurred at all training events and as usual we have encouraged our staff attendance at a relevant conference/external training events. We as a department maintained a "business as usual" approach in ensuring our placements all continued and value the importance of such placements

We have had regular Q&A sessions within our pharmacy team during the ongoing pandemic which has provided support and reassurance for all our staff. Our management team provide regular 1:1 sessions for their staff and health and wellbeing conversations in these sessions are always a priority.

All our staff complete the mandatory trust equality and diversity training and we ensure our panels for interview are inclusive and staff interviewing have completed the relevant recruitment training. The trust

has a cultural ambassador programme too and training for staff can be provided by our cultural ambassador leads and they can offer to support at interview also. The impact of such strategies will be measured/monitored by the organisation.

AHPs

Less face to face clinical contact and the loss of informal support networks through home/remote working led to a greater reliance on remote technology and development of innovative ways of working to deliver placements:

- Leadership placements were developed where students worked in pairs within non-clinical environments to meet competencies.
- The coaching model has been an early success in that multiple students can be accommodated, supporting those environments with reduced capacity. The model allows for increased supervision and support and has been positively evaluated by students, HEI staff, educational supervisors and clinical teams.
- Projects were introduced into the learning environment to enable students to meet their competencies where clinical opportunities were reduced (as a result of the pandemic and changed working practices).

Educator training and induction for learners was offered online.

Practice placement group (developed and chaired by CNTW staff) offers mutual support and sharing of good practice across the ICS footprint and includes healthcare providers, HEI and HEE representation.

PPF supported students with additional learning needs, extending length of placements and hours to improve their placement experience. Impact of efficacy of the strategies implemented was measured via provision of additional meetings and student and supervisor feedback. Adaptive technology/software changes were successfully implemented to meet students' needs.

Clinical Psychology:

Less face to face clinical contact and the loss of informal support networks through home/remote working led to a greater reliance on remote technology and development of innovative ways of working to deliver placements:

- Remote learning opportunities offered in line with pathway-specific knowledge and expertise e.g. Experiential remote learning eg neuropsychological assessment, DBT skills
- Local inductions and in-house training were made available to trainees
- Clinical work that could be done remotely using one-consultation platform
- FtF clinical work following risk assessments conducted jointly with the university and CNTW

In terms of promoting diversity in psychological professions, university promoting in recruitment and have employed an EDI p/t lead. CNTW has implemented HEE-funded paid work experience project for people from diverse and disadvantaged backgrounds, this also provides a developmental opportunity for staff.

Medical:

Covid19 – The pandemic has impacted the clinical learning environment in a number of ways, there have been necessary changes to ensure IPC measures which have led to changes in the ways some services are delivered and clinicians and the wider teams have worked. There have also been changes in clinical demand, some directly linked to the pandemic and others indirectly. These changes have had the potential to impact team working as well as support systems and a number of measures have been implemented in order to manage this risk, as well as to support staff with the changing demands. Measures have included, but are not limited to the list below:

- Weekly online forum – a weekly online forum chaired by the DME and open to all trainees across the trust.
- Covid19 workbook – the rapidly change nature of the pandemic in relation to guidance and management made it difficult for trainees and indeed clinicians to keep abreast of best practice. This has become a key reference document for the trust and more widely, indeed on request it has been shared with the Royal College of Psychiatrists who have linked it with their own guidance.
- Gold command links – Members of both the medical education and multi-professional training teams having close links with, and regular attendance at the trust Gold Command centre has allowed training needs to be considered at all times and a rapid flow of information.
- Close work with trainees to look at ways to ensure increased clinical pressures can be met while considering impact on training and work life balance. This included measures such as the introduction of a training rota and changes to out of hours support to match change in demand
- To provide additional support to Newcastle Medical students we introduced a mentor scheme, whereby small groups of students are linked up with a clinical mentor who meets with them once a week
- Induction for trainees, trainee educational events including psychotherapy and support for trainers all made available remotely. Laptops were bought to allow AHP and medical students to access placements remotely

Equality, Diversity and Inclusion strategies:
CNTW have an equality and diversity strategy that was developed in 2018 and has board approval. This outlines clear outcomes that are reviewed regularly and progress measured against.
Specifically within the medical education faculty we look at our staffing groups according to gender and ethnicity in order to determine whether the faculty is represented of the wider medical group in relation to these characteristics. We some years ago identified that in relation to higher trainers there was an under representation of female staff and we have implemented, with the school a strategy to address this. We have also worked with trainees to look specifically at the issue of discrimination in the workplace following this developed specific training from both trainees and trainers in order to increase awareness of this and support all groups in managing this when experienced or witnessed. This is an ongoing piece of work we are evaluating, with links with HEE and the school

Domain 2 Educational governance and leadership

- Learners have identified difficulties both in raising concerns about training, patient safety and in receiving timely feedback when they have reported a particular issue. Please describe details about your organisation's policies and processes in this regard.
- HEE's new 2021 Education Contract sets a new framework for financial governance with LEPs. Please describe how you manage this to ensure quality standards are met. How are resources allocated within the education contract have used to provide specific support to trainers and educators.

Multi-professional:
Nursing
The practice education team has recently appointed a team manager who has responsibility for liaising with university, trust staff and students to facilitate timely resolution of student concerns. Tripartite meetings are used to discuss student issue before they become an issue. The practice education team manager meets monthly with heads of Universities to discuss and resolve recurring key themes.
Once a student has raised a concern it swiftly addressed. Students are actively encouraged to give feedback.
The trust has a policy for raising concerns and also a Freedom to speak up guardian. The freedom to speak up guardian has delivered a presentation at recent training delivered by CNTW staff to students.CNTWHR06-RaisingConcerns-V05.1-Dec-19.pdf

The effects of COVID have undoubtedly affected the clinical placements available to students, however CNTW has shown great creativity in finding alternative placements to maximise the students learning
All students have an online induction before placements in CNTW

Pharmacy
As above this was not an issue. All aspects of educational governance and leadership was maintained as before. As a department we haven't received any complaints from learners. We do constantly evaluate and obtain feedback on our different placements both at an undergraduate and postgraduate level and any issues raised are discussed within the departmental workforce meetings.

Our organisation has a freedom to speak up guardian and freedom to speak up champions who can be contacted by anyone working in our trust students, trainees included. This is about having a culture in which people working in our Trust feel free to raise concerns.

Our organisation has defined procedures in place regarding patient safety and any incidents both medication related and non medication related can be reported through our web-based incident reporting system.

We work closely with CNTW Learning Academy and also HEE School of Pharmacy and Medicines Optimisation in the region to ensure resources are provided to support our trainers and educators.

AHPs and Psychological Services
Students have a comprehensive induction (equivalent to the staff induction) which includes governance issues: outlining policies and procedures e.g. whistleblowing, safeguarding etc.
Students have allocated leads: PPF, HEI and clinical supervisor to provide a safeguard to ensure issues aren't overlooked/missed. This system ensures support across organisations and timely feedback is collated and responded to appropriately.
Robust supervision structures are in place alongside a no-blame culture of openness and transparency
No complaints from AHP or Clinical Psychology / IAPT students / trainees have been received via the PPF to escalate through formal feedback processed
HEIs host regular forums for students and educators during placements to address any concerns, our PPF also attends and supports the process.

Resources have been allocated to purchase additional laptops to support remote working
Training sessions have been provided to educators

Medical:
All junior doctors are supported through a range of support systems through which they can raise concerns about training or patient care. The governance systems available are discussed at induction, in addition to the options of raising issues there are specific systems set up where junior doctor experience is reviewed with junior doctors. This includes through regular weekly supervision, mid placement reviews, end of post feedback forms, local trust clinical governance systems as well as through the guardian forum. Trainees all have local college tutors who can support them within their locality and in addition to this there are trust-wide tutors for each group of trainees. There is also a trainee led initiative where junior doctors meet to look at training or service issues and then work with the medical education or operational teams to implement improvements, this group has been pivotal in the work being done on discrimination. During the pandemic we have set up additional online forum to provide open access to junior doctors to raise concerns around training and clinical services, this has worked well and allowed rapid responses to local issues as they have arisen.
Within CNTW all medical training monies, both UG and PG are ring-fenced to ensure they are used to support training. Within the UG monies the budget comes into an UG budget, managed by the DME and AMD UG, this ensures the money follows students and supports teaching. We have developed and have

support from the Executive Director of Finance for a new approach with the money linked to Sunderland Medical School, in this model there is a greater emphasis on dedicated job planned teaching time, mirroring the approach we have with our PG finances. If this approach works well our plan is to adopt this with the Newcastle University money. PG funds are again managed within an identified medical education budget line with the DME and AMD PG being responsible. This budget as well as including training money also is added to so all junior doctors costs sit within the one budget, having this sitting with the medical education teams ensures a focus remains on quality of training experience

Domain 3 Supporting and empowering learners

- Facilities provided to trainees and learners have been identified as a potential need. Please provide details about specific resources and initiatives you have in place.
- Please describe the health and wellbeing initiatives you have in place for trainees and learners and how you measure their impact.

Multi-professional:

Nursing

Nursing and AHP students have access to the same facilities as CNTW staff. For example they can access the library, wellbeing services, online resources, schwartz rounds etc.
CNTW employs education support nurses specifically to support nursing and AHP students whilst on their placements
Laptops were bought to loan to students throughout the pandemic, this is ongoing.
Students must provide feedback on all of their placements before they can move to the next one. Any negative feedback comes to the practice education team along with the placement. This is then investigated and any changes that need to be made are.
Nursing apprentices have regular feedback sessions with the education support nurses
The universities use simulation suites to provide as much practical training as possible

Pharmacy

No issues noted.

When students/trainees come to our sites they have adequate rest/changing facilities. We provide pharmacy scrubs uniform for our rotational pharmacy staff and trainees/undergraduate students come with their own uniform scrubs.

Health and wellbeing conversations are always addressed in 1:1s with staff and any trainees who come to our department are provided with a timetable in advance and welcome meetings with the relevant staff members. Use of site gyms is available to our trainee pharmacists and access to other health and wellbeing initiatives and support available is highlighted on our thrive website Thrive at CNTW | Home | NHS Thrive

AHPs and Psychological professions

Laptops and mobile phones have been provided for staff and students.
Health and wellbeing hub, access to psychology help line, access to free yoga sessions, gym facilities, support from occupational health, specific local projects have been developed by students and staff to support wellbeing.
Students on placement receive copies of 'AWISH,' our staff health and wellbeing bulletin (Advice, Wellbeing, Information and Self-Help).
Peer support encouraged and facilitated wherever possible.

IAPT

Learners were supported to use a range of technologies with respect to attending training sessions, shadowing other staff and delivering their own interventions. Where face-to-face sessions have been

allowed, trainees have been prioritised for the limited clinical space in order to maximise their experiences and ensure they are comfortable with both remote and in-person clinical work.

Medical:
We have provided all speciality trainees with laptops to support access to remote learning and improve efficiency in out of hours work. We have additionally in the last year been able to invest heavily in a new Medical education centre within the trust which has within it facilities to support simulation based learning. This also includes space for junior doctors to socialise. In addition to this over the last two years we have worked through our Guardian forum to improve the facilities available for junior doctors, this has included providing rest facilities as well as leisure facilities within on call rooms. We have signed up to the junior doctor BMA charter and work closely with junior doctors to look at ways of supporting their work life balance. We have identified a need to improve facilities for junior doctors and undergraduates within our North Cumbria site due to changes in the amount and way education is being delivered on site. Short term measures have ensured the on-call room meets essential standards however this is something we want to improve as part of our investment in training and education with N Cumbria
Trainers are encouraged to consider welfare with trainees as part of regular 121 weekly meetings and within these we also encourage trainers to take a flexible approach to work schedules to meet trainee need

Domain 4 Supporting and empowering educators

- Please describe 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.
- Please describe the health and wellbeing initiatives you have in place for trainers and educators, and how you measure their impact.

Multi-professional:
<u>Nursing</u>
The practice education team manager attends regular locality wide meetings to promote the support and training available to all clinical teams.
The practice education team manager has negotiated with the university heads to use their simulation suites. The aim is to alleviate some of the pressure within CNTW and to provide students with an excellent learning experience.
The practice education leads deliver trust wide training to qualified nurses to become practice assessors and supervisors.
The trust has invested in the practice education team and increased its staff numbers.
The bulletin is used to communicate important student related information and courses.
The trust has a very wide range of support available to all members of staff.

<u>Pharmacy</u>
Educational supervisor training provided by HEE has been taken up by several of our staff members involved in education and training. Staff have also been offered the opportunity of enrolling onto the mentor skills training programme provided by HEE. Regular support for staff members at their 1:1s with their managers is provided and for any staff members who highlight any additional educational training needs in their PDP/1:1s; these will be addressed and supported by our department. As a department we are keen to promote the development of our staff and are supportive of their supervision needs with any learners in our organisation.

There is a pre-registration trainee pharmacist pack and also a university placement pack developed with sample learning opportunities/resources for learners which link in with their associated learning curricula. These resources can be used alongside their clinical time on placement.

Health and wellbeing conversations are a key part of all 1:1 sessions managers and staff have on a regular basis within our department. We promote our trust's flexible working policy from day 1. Due to ongoing pressures during the pandemic where remote learning was required; staff members were provided with the necessary and appropriate equipment to do so.

AHPs
Recruitment of dedicated PPF provided support and training
Use of Teams including online training packages
Developed and increased the number of long arm placements which reduces pressures for educators
Ongoing development of the coaching model
Utilising AHPs as educators who aren't working in traditional roles takes pressure off the existing cohort of clinical educators e.g. PCN, leadership placements, OTs working as CBT therapists

PPF offers support, out of hours access and training to ensure educators are supported, numbers of educators has not decreased, demonstrating this is felt to be supportive and enabled them to continue to offer the same number and quality of placements as pre-Covid

Clinical Psychology
Associate Directors and professional leads have provided support and advocated for continued provision of CP placements and attached supervision throughout the pandemic. Liaison with university re flexibilities needed, and how to adapt to remote working and to reintroduce FtF working.

All:
Pyramid of staff health and wellbeing offers developed and made as accessible as possible

Medical:
The Faculty Development Programme courses for trainers have continued to run remotely throughout this reporting year and were well attended. The Supervising Your Trainee & Line Management course and Supervisor Refresher course in particular have had excellent attendance, showing very strong commitment from both new and existing clinical supervisors in the trust. Although some attendees still prefer face to face teaching, delivery via Teams has made all of the courses much more accessible and allowed attendance when time constraints and physical distance would have prevented this.

Domain 5 Developing and implementing curricula and assessments

- All training has been affected by the pandemic to varying degrees. Please describe 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. Please describe how your plans for this include maintenance of education and training.

Multi-professional:
Nursing
Good working relationships with the universities are well established with excellent lines of communication. Universities and CNTW are working together to deliver student training.
All universities have simulation suites and are agreeable to sharing them with CNTW.
Over 300 student nurses were employed during the first lockdown.
Business continuity is reviewed on a daily basis and action taken when necessary.
Northumberland University share the nursing student's curriculum with the practice education team.

Pharmacy
N/A for CNTW pharmacy

We have maintained business as usual throughout the pandemic and ensured our clinical placements for students and trainees continued throughout.

AHPs and Psychological Professions

CNTW AHP and Psychological services staff regularly teach at HEIs. This is delivered remotely and agreements are in place for teaching commitments for the next academic year
Maintained (and in some areas increased) the required number of placements to ensure students are not disadvantaged by the current situation.
Working collaboratively with the HEIs to maintain delivery of high quality training and placement provision – remote teaching, creative adaptation of teaching material and methods, access to shared drives, webinars across specialities. Special interest groups have shared resources

Medical:
The core course regional teaching continues to be delivered online and on schedule. The postgraduate teaching is now regularly delivered online and the time protected for trainees to attend. The trainee development programme and faculty development programme is regularly reviewed and trainees encouraged to attend them appropriate to their level of training. Plans to recommence training via simulation is underway.

Domain 6 Developing a sustainable workforce

- Please identify any 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. Please describe how you intend to work collaboratively to plan for the long term needs of the North East and North Cumbria.

Multi-professional:
Nursing
Recruitment and retention remains a high priority.
Sunderland and Northumbria Universities have recruited large numbers of nursing students which CNTW have supported. Although challenging, we have agreed to facilitate this to grow our own workforce.
We continue to support and recruit to the nursing apprentice, nursing associate and advanced clinical practitioner programmes.
Universities and CNTW have close working links – we will use this to jointly negotiate student numbers based on what the trust needs.
The practice education team manager works strategically with ICS

Pharmacy
CNTW pharmacy is an active member of the ICS NENC workforce group and has worked collaboratively across the system to put in place a workforce plan for the ICS. We haven't identified any barriers to the collective ICS approach to education and training. We work closely with the School of Pharmacy and Medicines Optimisation in the region in promoting education and training opportunities and ensuring a system wide approach to this.
CNTW are already involved in a NENC Pharmacy Workforce Group to take forward the learning disability and autism agenda across all sectors in the NENC ICS. CNTW pharmacy department have worked with the ICS looking at mental health knowledge and skills within the Pharmacy System and presented strategic recommendations to address the issues raised

AHPs
Several localities and professional groups are difficult to recruit to, particularly SALT and Dietetics. Our workforce development lead (post funded by HEE) is working to develop a staffing matrix to understand the make-up of the current AHP workforce, highlight vulnerable area/professions and develop a strategic plan to incorporating identified areas for development.
AHP faculty and AHP council are both chaired by CNTW AHPs providing strong links across the region
CNTW member of staff chairs the national AHP faculty group

Clinical Psychology

Recruitment to inpatient qualified posts has been very problematic and this links to a lack of selection of placements in these settings. Also recruitment more broadly at B7 (entry level for qualified CPs). This reflects some border issues, different workforce approaches in Scotland vs England. There is a MH workforce workstream within the ICS at which CNTW is represented. New roles such as the MHWP and Youth intensive practitioner for CYPS are being embraced and will contribute very positively to skill mix.
Medical In relation to vulnerabilities for workforce, this is impacted on by both sub-speciality and geographical location. Within the geographical area covered by CNTW the area of N Cumbria remains the most challenging to recruit to. Over the last year the level of this challenge has necessitated review and change of training posts as well as service. Although this is challenging there have been a number of positives with recruitment of new consultant staff, development of 24 hour first on call making the posts more attractive and recruitment of international Fellows. We are hoping to look at further innovative solutions including the introduction of medical assistants and looking at how higher training posts and the CESR Fellowship scheme could complement each other within N Cumbria to allow more doctors to have their training based in Cumbria, particularly people wanting to live in the area longer term. In relation to sub-specialities we are aware that although core and higher training posts are more consistently well recruited to, there remains a difficulty in filling the LD scheme and we are working with the school to look how to promote this better. We are also conscious that provision of higher training posts in the South of the region (outside CNTW) has been challenging we continue to be able to provide these within the trust, ensuring the scheme can offer a good choice of posts. In relation to expansion, this is something we are keen to do across all specialities, the priority would be expansion of ST posts as this an area we are particularly under-provided with and we are aware is particularly important for consultant recruitment, which is critical to our ongoing service delivery. In terms of ICS mental health workforce planning, this is coordinated through a Mental Health workforce subgroup of the ICS mental health work-stream. Workforce implications are also discussed in relation to each of the ICS MH work-stream priority areas. The MH workforce subgroup is chaired by CNTW's Medical Director, which has allowed good communication and alignment of trust and ICS priorities. We also have links into both the college workforce planning group, with CNTW DME being a member of this group and the HEE NE&NC psychiatry workforce group, a group which allows collaboration between the big MH trusts to optimise regional planning. A good example of this has been the shared learning and experiences the trusts have had around the development of Physicians Associates and Medical Assistants within mental health services.

Section 2: Statements of assurance & exception reporting to standards

2.1 Multi-professional

2.1.1 Assurance statement & exception reporting against HEE quality domains & standards

a) Programme's assurance summary

Please check the box in column 1 for all multi-professional programmes within your organisation which you are reporting and declaring assurance for. Please select whether you are meeting all standards for these by checking the appropriate box in columns 3-5.

	Programme	Meeting ALL requirements	Some PARTIALLY met	Some NOT Met
Allied Health Professionals				
☒	Art Therapist	☒	☐	☐
☒	Dietician	☒	☐	☐
☒	Drama Therapist	☒	☐	☐
☒	Music Therapist	☒	☐	☐
☒	Occupational Therapist	☒	☐	☐
☐	Operating Department Practitioner	☐	☐	☐
☐	Orthoptist	☐	☐	☐
☐	Optometrist	☐	☐	☐
☐	Osteopath	☐	☐	☐
☒	Physiotherapist	☒	☐	☐
☐	Podiatrist	☐	☐	☐
☐	Prosthetist/Orthotist	☐	☐	☐
☐	Radiographer - Diagnostic	☐	☐	☐
☐	Radiographer - Therapeutic	☐	☐	☐
☒	Speech & Language Therapist	☒	☐	☐
Ambulance Service Team				
☐	Emergency Medical Technician	☐	☐	☐
☐	Paramedic	☐	☐	☐
Dental Team				
☐	Dental Hygienist	☐	☐	☐
☐	Dental Nurse	☐	☐	☐
☐	Dental Technician & Clinical Dental Technician	☐	☐	☐
☐	Dental Therapist	☐	☐	☐
☐	Orthodontic Therapist	☐	☐	☐
Health Informatics				
☐	Clinical Informatics	☐	☐	☐
☐	Libraries & Knowledge Management	☐	☐	☐
Healthcare Sciences				
☐	Clinical Bioinformatics Genomics	☐	☐	☐
☐	Health Informatics	☐	☐	☐
☐	Physical Sciences	☐	☐	☐
☐	Life Sciences Analytical Toxicology	☐	☐	☐
☐	Clinical Biochemistry	☐	☐	☐
☐	Clinical Immunogenetics	☐	☐	☐
☐	Genetics	☐	☐	☐
☐	Haematology	☐	☐	☐
☐	Histocompatibility & Immunogenetics	☐	☐	☐
☐	Microbiology	☐	☐	☐
☐	Molecular Pathology of Acquired Disease	☐	☐	☐
☐	Molecular Pathology of Infection	☐	☐	☐
☐	Reproductive Science	☐	☐	☐
☐	Virology	☐	☐	☐
☐	Physical Sciences Clinical Biomedical Engineering	☐	☐	☐
☐	Clinical Pharmaceutical Science	☐	☐	☐
☐	Medical Physics	☐	☐	☐
☐	Rehabilitation Engineering	☐	☐	☐
☐	Renal Technology	☐	☐	☐
☐	Physiological Sciences Audiology	☐	☐	☐
☐	Cardiac physiology	☐	☐	☐
☐	Critical Care Science	☐	☐	☐
☐	Gastrointestinal & Urological Sciences	☐	☐	☐
☐	Neurophysiology	☐	☐	☐
☐	Ophthalmic & Vision Sciences	☐	☐	☐
☐	Respiratory & Sleep Physiology	☐	☐	☐
☐	Vascular Science	☐	☐	☐
Medical Associate Professions				
☐	Advanced Critical Care Practitioner	☐	☐	☐
☐	Advance Clinical Practitioner	☐	☐	☐
☐	Anaesthesia Associate	☐	☐	☐
☐	Physician Associate	☐	☐	☐
☐	Surgical Care Practitioner	☐	☐	☐
Nursing & Midwifery				
☐	Adult Nurse	☐	☐	☐
☒	Children's Nurse	☐	☒	☐
☒	Learning Disability Nurse	☒	☐	☐
☒	Mental Health Nurse	☒	☐	☐
☐	Midwife	☐	☐	☐
☒	Nursing Associate	☒	☐	☐
☐	Specialist community public health nursing (SCPHN)	☐	☐	☐
Pharmacy				
☒	Pharmacist	☒		
☒	Pharmacy Technician	☒	☐	☐
Psychological professions				
☒	~~Counselling~~ Clinical Psychologist	☐	☒	☐
☐	Counsellor	☐	☐	☐
☐	Education Mental Health Practitioner	☐	☐	☐
☒	High Intensity Therapist	☒	☐	☐
☐	Psychological Wellbeing Practitioner	☐	☐	☐
☐	Psychotherapist	☐	☐	☐

b) Programme declarations by requirement

Using the intelligence gained through your governance structures, please consider all themes, standards and requirements in the table below and declare all programmes and posts where standards and requirements are met, partially or not met. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Illustrative example of how to complete the declaration

Domain 1 Quality Standards	***Met***	***Partially met***	***Not met***
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	***All** Met*		
Domain 5 Quality Standards	***Met***	***Partially met***	***Not met***
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	*All Met, with the exception of those programme listed in partially met/not met*	***Adult Nursing** – some issues with curriculum coverage during C19. See QIP for plan.*	

Declaration for completion

Domain 1 Learning environment and culture			
Domain 1 Quality Standards	**Met** *If all professions in scope meet the standard, please state 'All'* *If not all professions meet the standard please state:* *'All professions meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	All		
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	All		
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	All However more opportunities for AHP students to be involved in research and innovation are being pursued to further enhance the learners' experience		
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	All		

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	All	Increased number of students on placement and restrictions on office space and on clinical practice changes in response to Covid 19 has led to issues in relation to access to IT hardware and safe, appropriate spaces for students across the Trust. Clinical Psychology – only hot desk space or working from home. Laptop access has been more challenging for trainees outside of CNTW	
1.6 The learning environment promotes inter-professional learning opportunities.	All	Clinical Psychology – less so during pandemic due to remote working and reduced office capacity	
Domain 2 Educational governance and leadership			
Domain 2 Quality Standards	**Met**	**Partially met**	**Not met**
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	All		
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	All		
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	All		
2.4 Education and training opportunities are based on principles of equality and diversity.	All		
2.5 There are processes in place to inform the appropriate stakeholders when	All		

performance issues with learners are identified or learners are involved in patient safety incidents.			
Domain 3 Supporting and empowering learners			
Domain 3 Quality Standards	**Met**	**Partially met**	**Not met**
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	All		
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	All		
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	All		
3.4 Learners receive an appropriate and timely induction into the learning environment.	All		
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	All		
Domain 4 Supporting and empowering educators			
Domain 4 Quality Standards	**Met**	**Partially met**	**Not met**
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	All		
4.2 Educators are familiar with the curricula of the learners they are educating.	All		
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	All		
4.4 Formally recognised educators are appropriately supported to undertake their roles.	All		
Domain 5 Delivering curricula and assessments			
Domain 5 Quality Standards	**Met**	**Partially met**	**Not met**
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	All		
5.2 Placement providers shape the delivery of curricula, assessments and	All		

programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.			
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	All	All	
Domain 6 Developing a sustainable workforce			
Domain 6 Quality Standards	**Met**	**Partially met**	**Not met**
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All. Student concerns proactively addressed to reduce attrition		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	All. We have a dedicated member of staff for this role		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	All		
Declaration of assurance (Multi-professional section approval) *Sign off from the nominated person, on behalf of the executive team.*			
Name and Role: **Date:**	Louise Wicks, Practice Education Team manager		

2.1.2 Multi-professional good practice items

Please list any good practice items that you would like to highlight to HEE. These may include trust wide initiatives as well as departmental / unit examples. Any items listed here will be uploaded to HEEs Good Practice System for sharing across the region. You do not need to duplicate items from the successes section of the SAR (section 1).

	Good Practice Items						
	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7
What was implemented and why?	To support the Trust clinical placement expan	Establishment of rotational pharmacist placements in mental health with 4 local acute trusts	Collaboration of consultant psychiatrists, pharmacists from CNTW and TEWV to establish a “safe prescribing in mental health ”	Monthly development sessions for our new clinical pharmacy staff	Long arm and multi-professional role emerging placements	Creative use of PFF, managers and those in leadership positions to manage pressures on staffing	Development of placement innovation group

	sion programme the Practice Education Team have worked in collaboration with the Trust Academy to develop an internally facilitated PA/PS module which will see an increase in numbers across all services and provide underpinning structure for expansion		module – supported by the School of Psychiatry, HEE NE/NC	and for existing staff wishing to upskill in some of the core mental health topics. These sessions have been delivered by TEAMS and the link has been shared with some of our local acute trust pharmacy departments namely Newcastle Hospitals NHS Foundation Trust (NuTH) and Northumbria Healthcare NHS Foundation Trust (NHFT). We have also			

				joined in some of the training sessions offered by our colleagues at NuTH. The adoption of TEAMS for such meetings/events during the C19 pandemic has ensured this shared learning is now possible between pharmacy teams in the region.			
Profession(s) it relates to		Multiprofessional (pharmacy)	Multiprofessional (pharmacy), medical	Mutiprofessional (pharmacy)	OT, PT	OT, PT, arts psychotherapist	All AHPs
HEE domain(s) and standard(s) it relates to		6, 6.3	1, 1.1, 1.6	6, 6.3	1,2,3,4	4	2
Benefits or positive		Increased exposure to mental health which may have positive benefits	This series of 5 workshops were developed for psychiatry trainees and	This helps promote increas	Direct clinical benefit- reduced admission time, articulated need	Supportive sense of sharing the load demonstrated	Increased network links Sharing good practice

impact ?		in terms of bolstering our future workforce but also ensuring our local acute trust pharmacists in the region are upskilled in mental health and medicines optimisation of psychotropics and assuring parity of esteem for our service users. This also increases our collaborative links with our acute trust partners.	non-medical prescribers based in CNTW and TEWV NHS FTs. Delivery as 1 hr sessions via MS TEAMS with the aim of being multiprofessional interactive workshops covering key principles and practices relating to safe prescribing in mental health services. This was a good example of multi professional collaborative working across organisations.	ed learning opportunities between organisations and improves communication in view of "working as one" and also helping to endorse the mental health champion role.	for physiotherapy within a service not currently employed in. Highlighted benefits PT can bring to the service Improved links with acute hospital partners	Benefits of others demonstrated to MDT Use of students as a positive resource	
Lessons learned and difficulties encountered			Delivered via TEAMS, maybe better engagement if face to face		Highlighted necessity to increase communication channels Reflection allowed for development of future placements Acknowledgement of how much preparation work is required to allow it to be successful	Anxiety aroused for those who haven't had students previously needs containing and addition training provided	Amount of time it takes to facilitate in addition to current post
Contact for further information (name, role, email, telephone	Marc House and John Salkeld	Martina Khundakar, lead pharmacist, martina.khundakar@cntw.nhs.uk	Martina Khundakar, lead pharmacist, martina.khundakar@cntw.nhs.uk		Devra Deltodesco, PPF Devra.Deltodesco@cntw.nhs.uk	Devra Deltodesco, PPF Devra.Deltodesco@cntw.nhs.uk	Julie Morrow Deputy Director AHP and Psychological Services Mobile: 07966275326

numb er)							E Mail: julie.morrow @cntw.nhs.u k

Please add these and any additional items that you would like to share with the region to the 'Good Practice System' here

2.1.3 Multi-professional challenges / important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the profession / professions)	**HEE Domain(s)**	**HEE Standard(s)**
As mentioned already in 1.3		
Redeployment. The practice education team have all been redeployed at various points over the course of the covid pandemic. They have had 3 interim team managers until the permanent manager was appointed in summer 2021. This has affected their ability to work strategically.	Nursing/AHP	
Staff absence is incredibly high. This is having a substantial knock on effect on the amount of clinical placements available.	Nursing/AHP	
Provision of pharmacy services in the North Cumbria region and its associated workforce pressures and the difficulty in training a workforce over a large geographical area.	6	6.3
Recruitment of pharmacy workforce due to emergent roles in other sectors e.g. pharmacists in primary care network workforce	6	6.3
Due to Covid-19 workforce pressures there have been challenges with certain aspects of education and training and the delivery of this due to student/trainee engagement and also the use of non face to face teaching methods in addition to staff absences due to C19/isolation.	3	3.1
Capacity challenges: Increase of university places, expansion of placements, AHPs being able to supervise nursing students and apprenticeships for AHPs coming on line in 2022 will all put additional pressure on the system of available placements and educators.	4	Supporting and empowering educators
Service redesign will be a major factor over the next 3-5 years particularly in relation to community mental health services. Pathways will be in a state of flux at times, as will the roles of staff supervising students.	3	Supporting and empowering learners
IAPT: The system (HEE, local services) became aware that IAPT HI trainees studying at Newcastle University were on a two year course but local services were only receiving funding for salary for one year (and at 60%). This presents a problem in terms of it being sustainable unless the course lengths match the funding length. This has been	2 & 6	Educational governance, workforce sustainability,

communicated to HEE and they have started discussions with Newcastle University but it has not yet been resolved in a way that addresses the problem.		partnership working
Clinical Psychology: A range of concerns have been identified about the identification of placements and partnership working with Newcastle University. Delays in resolving these issues could impact on the expansion programme for Clinical Psychology training in line with NHS Long Term Plan.	2 & 6	Educational governance, workforce sustainability, partnership working

2.2 Postgraduate medical

2.2.1 Organisation assurance statement and exception reporting against the GMC quality themes (GMC Promoting Excellence), standards and requirements and the HEE domain 6 standards

a) Programmes assurance summary

Please check the box in column 1 for all programmes within your organisation which you are reporting and declaring assurance for. Please select whether you are meeting all requirements for the programmes you are reporting for by checking the appropriate box in columns 3-5.

Provided in organisation	Programme	Meeting ALL requirements	Some PARTIALLY met	Some NOT Met
School of Acute Specialties				
☐	Acute Care Common Stem	☐	☐	☐
☐	Emergency Medicine	☐	☐	☐
☐	Paediatric Emergency Medicine	☐	☐	☐
☐	Pre-Hospital Emergency Medicine	☐	☐	☐
Dental Programme				
☐	Orthodontics	☐	☐	☐
☐	Restorative Dentistry	☐	☐	☐
☐	Paediatric Dentistry	☐	☐	☐
☐	Oral Surgery	☐	☐	☐
☐	Special Care Dentistry	☐	☐	☐
☐	Dental Public Health	☐	☐	☐
Anaesthesia & ICM				
☐	Anaesthetics	☐	☐	☐
☐	Core Anaesthetics	☐	☐	☐
☐	Intensive Care Medicine	☐	☐	☐
Foundation Programme				
☐	Foundation Year 1 Medicine	☐	☐	☐
☐	O&G	☐	☐	☐
	Paediatrics			
☒	Psychiatry	☒	☐	☐
☐	Surgery	☐	☐	☐
☐	Foundation Year 2 Medicine	☐	☐	☐
☐	O&G	☐	☐	☐
	Paediatrics			
☒	Psychiatry	☒	☐	☐
☐	Surgery	☐	☐	☐
General Practice				
☐	General Practice	☐	☐	☐
	Medicine			
☐	O&G	☐	☐	☐
☐	Paediatrics	☐	☐	☐
☒	Psychiatry	☒	☐	☐
☐	Surgery	☐	☐	☐
Laboratory Medicine				
☐	Chemical Pathology	☐	☐	☐
☐	Forensic Pathology	☐	☐	☐
☐	Histopathology	☐	☐	☐
☐	Immunology	☐	☐	☐
☐	Medical Microbiology	☐	☐	☐
☐	Neuropathology	☐	☐	☐
☐	Paediatric & Perinatal Pathology	☐	☐	☐
☐	Virology	☐	☐	☐
☐	Chemical Pathology	☐	☐	☐
Medicine				
☐	Acute Medicine	☐	☐	☐
	Stroke Medicine			
☐	Cardiology	☐	☐	☐
☐	Clinical Genetics	☐	☐	☐
☐	Clinical & Medical Oncology	☐	☐	☐
☐	Clinical Neurophysiology	☐	☐	☐
☐	Clinical Pharmacology	☐	☐	☐
☐	Core Medical Training	☐	☐	☐
☐	Dermatology	☐	☐	☐
☐	Elderly Care Medicine	☐	☐	☐
☐	Endocrinology & Diabetes Mellitus	☐	☐	☐
☐	Gastroenterology	☐	☐	☐
☐	Hepatology	☐	☐	☐
☐	General Internal Medicine	☐	☐	☐
☐	Genito-Urinary Medicine	☐	☐	☐
☐	Haematology	☐	☐	☐
☐	Infectious Diseases	☐	☐	☐
☐	Internal Medicine Training	☐	☐	☐
☐	Metabolic Medicine	☐	☐	☐
☐	Medical Oncology	☐	☐	☐
☐	Neurology	☐	☐	☐
☐	Occupational Medicine	☐	☐	☐
☐	Paediatric Cardiology	☐	☐	☐

☐	Palliative Medicine	☐	☐	☐
☐	Renal Medicine	☐	☐	☐
☐	Rehabilitation Medicine	☐	☐	☐
☐	Respiratory Medicine	☐	☐	☐
☐	Rheumatology	☐	☐	☐
Obstetrics & Gynaecology				
☐	Community Sexual & Reproductive Health	☐	☐	☐
☐	Obstetrics & Gynaecology	☐	☐	☐
☐	Gynaecological Oncology	☐	☐	☐
☐	Maternal & Fetal Medicine	☐	☐	☐
☐	Reproductive Medicine	☐	☐	☐
☐	Urogynaecology	☐	☐	☐
☐	Genitourinary Medicine	☐	☐	☐
Ophthalmology				
☐	Ophthalmology	☐	☐	☐
☐	Medical Ophthalmology	☐	☐	☐
Paediatrics				
☐	Paediatrics	☐	☐	☐
☐	Child Mental Health	☐	☐	☐
☐	Community Child Health	☐	☐	☐
☐	Neonatal Medicine	☐	☐	☐
☐	Paediatric Diabetes & Endocrinology	☐	☐	☐
☐	Paediatric Intensive Care Medicine	☐	☐	☐
☐	Paediatric Gastroenterology, Hepatology & Nutrition	☐	☐	☐
☐	Nephrology	☐	☐	☐
☐	Neurodisability	☐	☐	☐
☐	Neurology	☐	☐	☐
☐	Oncology	☐	☐	☐
☐	Respiratory Medicine	☐	☐	☐
☐	Rheumatology	☐	☐	☐

Psychiatry				
☒	Adult Mental Health	☒	☐	☐
☒	Child & Adolescent Mental Health	☐	☒	☐
☒	Forensic Psychiatry	☒	☐	☐
☒	General Psychiatry	☒	☐	☐
☒	Liaison Psychiatry	☒	☐	☐
☒	Rehabilitation Psychiatry	☒	☐	☐
☒	Substance Misuse Psychiatry	☒	☐	☐
☒	Learning Disability	☒	☐	☐
☒	Old Age Psychiatry	☒	☐	☐
Public Health				
☒	Public Health Medicine	☒	☐	☐
Radiology				
☐	Clinical Radiology	☐	☐	☐
☐	Interventional Radiology	☐	☐	☐
Surgery				
☐	Cardio-thoracic Surgery	☐	☐	☐
☐	Core Surgical Training	☐	☐	☐
☐	General Surgery	☐	☐	☐
☐	Neurosurgery	☐	☐	☐
☐	Oral & Maxillo-Facial Surgery	☐	☐	☐
☐	Otolaryngology	☐	☐	☐
☐	Paediatric Surgery	☐	☐	☐
☐	Plastic Surgery	☐	☐	☐
☐	Trauma & Orthopaedic Surgery	☐	☐	☐
☐	Urology	☐	☐	☐
☐	Vascular	☐	☐	☐

b) Programme declarations by requirement

Using the intelligence gained through your governance structures, please consider all of the themes requirements in the table below and declare all programmes and posts where requirements are met, partially or not met. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Illustrative example of how to complete the declaration

Domain 1 Quality Requirements	***Met***	***Partially met***	***Not met***
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	***All** Met*		
R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.	*All met, except for those programmes listed as partially / not met*	***Trauma and Orthopaedics, Urology***	***Core Surgical Training, General Surgery, ENT, Plastics,*** *(Significant challenges detailed within the QIP).*

Declaration for completion

Theme 1 Learning environment and culture **Standards**

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.			
Theme 1 Quality Requirements	**Met** *If all posts/programmes in scope meet the requirement, please state 'All'* *If not all posts/programmes meet the requirement, please state: 'All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the requirement* *Please ensure all items declared as not met are added to the QIP*
R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences	All		
R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.	All		
R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.	All		
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	All		
R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.	All		
R1.6 Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should	All		

encourage learners to engage with these processes.			
R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.	All		
R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.	All		
R1.9 Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.	All		
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.	All		
R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent.5 Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.	All		
R1.12 Organisations must design rotas to: **a** make sure doctors in training have appropriate clinical supervision **b** support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK	All		

c provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme **d** give doctors in training access to educational supervisors **e** minimise the adverse effects of fatigue and workload.			
R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out: **a** their duties and supervision arrangements **b** their role in the team **c** how to gain support from senior colleagues **d** the clinical or medical guidelines and workplace policies they must follow **e** how to access clinical and learning resources. As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.		Partial: Child and adolescent higher trainee induction is not as well delivered as we would like, and this something we are aiming to develop over this year	
R1.14 Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.	All		
R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.	All		
R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.	All		
R1.17 Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.	All		

R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.	All		
R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.	All		
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	All		
R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.	All		
R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.	All		

Theme 2 Educational governance and leadership

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Theme 2 Quality Requirements	**Met**	**Partially met**	**Not met**
R2.1 Organisations must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.	All		
R2.2 Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their	All		

organisation and responding appropriately to concerns.			
R2.3 Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.	All		
R2.4 Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.	All		
R2.5 Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.	All		
R2.6 Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.	All		
R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.	All		
R2.8 Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.	All		
R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.	All		
R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.	All		

R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.	All		
R2.12 Organisations must have systems to manage learners' progression, with input from a range of people, to inform decisions about their progression.	All		
R2.13 (Not Applicable to Postgraduate Medical)			
R2.14 Organisations must make sure that each doctor in training has access to a named clinical supervisor who oversees the doctor's clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.	All		
R2.15 Organisations must make sure that each doctor in training has access to a named educational supervisor who is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.	All		
R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.	All		
R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.	All		
R2.18 Medical schools (and the universities of which they are a part)	All		

must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.			
R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.	All		
R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.	All		

Theme 3 Supporting learners

Standards

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

Theme 3 Quality Requirements	**Met**	**Partially met**	**Not met**
R3.1 Learners must be supported to meet professional standards, as set out in *Good medical practice* and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.	All		
R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including: **a** confidential counselling services **b** careers advice and support **c** occupational health services. Learners must be encouraged to take responsibility for looking after their own health and wellbeing.	All		
R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.	All		

R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010*.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.	All		
R3.5 Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.	All		
R3.6 When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.	All		
R3.7 Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.	All		
R3.8 Doctors in training must have information about academic opportunities in their programme or specialty and be supported to pursue an academic career if they have the appropriate skills and aptitudes and are inclined to do so.	All		
R3.9 (Not Applicable to Postgraduate Medical)			
R3.10 Doctors in training must have access to systems and information to support less than full-time training.	All		
R3.11 Doctors in training must have appropriate support on returning to a programme following a career break.	All		
R3.12 Doctors in training must be able to take study leave appropriate to their curriculum or training programme, to the maximum time permitted in their terms and conditions of service.	All		
R3.13 Learners must receive regular, constructive and meaningful feedback	All		

on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.			
R3.14 Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.	All		
R3.15 Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.	All		
R3.16 Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.	All		
Theme 4 Supporting educators **Standards** S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities. S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.			
Theme 4 Quality Requirements	**Met**	**Partially met**	**Not met**
R4.1 Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.	All		
R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.	All		
R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.	All		
R4.4 Organisations must support educators by dealing effectively with	All		

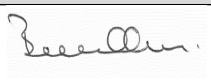
concerns or difficulties they face as part of their educational responsibilities.			
R4.5 Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.	All		
R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.	All		

Theme 5 Delivering and implementing curricula and assessments
Standards
S5.1 (Not Applicable to Postgraduate Medical)

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

Theme 5 Quality Requirements	**Met**	**Partially met**	**Not met**
R5.1 to R5.6 (Not Applicable to Postgraduate Medical)			
R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.	All		
R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.	All		
R5.9 Postgraduate training programmes must give doctors in training: **a** training posts that deliver the curriculum and assessment requirements set out in the approved curriculum **b** sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum **c** an educational induction to make sure they understand their curriculum and how their post or clinical placement fits within the programme **d** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation		5.9b 1) Core trainee clinical experience 2) Higher trainee professional experience	

e the opportunity to work and learn with other members on the team to support interprofessional multidisciplinary working **f** regular, useful meetings with their clinical and educational supervisors **g** placements that are long enough to allow them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress **h** a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by doctors in training should support learning opportunities wherever possible. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.			
R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through their education and training.	All		
R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.	All		
R5.12 Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the *Equality Act 2010*, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.	All		
HEE Domain 6 Developing a sustainable workforce			

(HEE Quality Framework)			
Domain 6 Quality Standards	**Met**	**Partially met**	**Not met**
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	All		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	All		
7. Providers must proactively develop and implement activities that will support individual learners to successfully transition from their education programme to employment. Feedback from learners needs to be utilised to develop activities and outcomes evaluated to assess the impact on retention levels and spread good practice.	All		
Declaration of assurance (Postgraduate medical section approval) *Sign off from the nominated person, on behalf of the executive team.*			
Name and role: **Date:**	Dr Bruce Owen Director of Medical Education		28/01/2022

2.1.2 Postgraduate medical good practice items

Please list any good practice items that you would like to highlight to HEE. These may include trust wide initiatives as well as departmental / unit examples. Any items listed here will be uploaded to HEEs Good Practice System for sharing across the region. You do not need to duplicate items from the successes section of the SAR (section 1).

	Good Practice Items		
	Item 1	Item 2	Item 3
What was implemented and why?	Training rota across NE	SI simulation training	Development of a monthly trust wide PG teaching programme
Profession(s) it relates to	Medical	Medical	Medical and open to all
HEE domain(s) and standard(s) it relates to	Domains 1,3 & 5	Domains 1 and 3	Domains 1, 3 and 4

Benefits or positive impact?	Opportunity for core and GP trainees to gain experience or and learn about MHA assessments out of hours.	Simulation based training allows trainees be prepared for the management of Sis and facing coroners court. This a training programme we have piloted, developed and now run as part of trainee development programme	Increasing use of remote learning approaches has allowed us to develop a monthly trust wide PG teaching programme to supplement the weekly local meetings. This has been hugely popular, with over 100 trainees and trainers attending across the trust enhancing learning as well as the culture of learning
Lessons learned and difficulties encountered	Experience valuable for core and GP trainees, important to work with ST trainees and be clear of goal	Covi19 pandemic delayed our ability to develop this initiative	Initially was key to align PG teaching sessions in localities to the same time to allow trust wide sessions to fit with existing time commitments
Contact for further information (name, role, email, telephone number)	Dr Bruce Owen	Dr Prathibha Rao	Dr Stuart Watson

Please add these and any additional items that you would like to share with the region to the 'Good Practice System' here

2.2.3 Postgraduate medical challenges / important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1).

Description of challenges (please include the programme this relates to)	**HEE/GMC Domain(s)**	**HEE/GMC Standard(s)**
Recruitment of trainers in North Cumbria The recruitment of trainers in North Cumbria has been a significant challenge for some years. The degree of this challenge has impacted services as well as training posts in North Cumbria. We have been able to maintain the number of posts as well as quality of training but are conscious the situation is fragile.	Domain 1	R1.8

Supporting high quality training and trainee welfare due to COVID impact. The impact of covid19 has changed during the course of the pandemic, with challenge around clinical care, delivery of training and more recently staffing numbers. We have throughout aimed to work with trainees and trainers to protect training while also ensuring good quality clinical care.	Domain 6	
Currently we are not as able to interpret the GMC trainee data as well as we would like due to difficulty with the ways posts are coded meaning they are not accurately aligned to the sites. We are aiming to address this be reviewing posts with colleagues in the LET and HEE NE&NC with a goal of grouping them according to broader out of hours rota sites. This will allow us to get a more complete picture of data and address areas where performance is less good.	Domain 2,3	

2.3. Undergraduate medical

2.3.1 Organisation assurance statement and exception reporting against the GMC quality themes, standards and requirements and the HEE domain 6 standards

Using the intelligence gained through your governance structures, please consider all themes, standards and requirements in the table below and declare all programmes and posts where standards and requirements are met, partially or not met. Please consider both placement and departments as well as trust wide policy, approach and ability to meet the standards and requirements in Promoting Excellence. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Illustrative example of how to complete the declaration

Theme 1 Quality Requirements	***Met***	***Partially met***	***Not met***
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.		*All partially met – there is a Trust roll-out of lanyards, supported by posters and infographics.*	
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	*All met with the exception of those listed in partially met / not met*	*Acute Medicine (detail in QIP)*	*Paediatrics (detail in QIP)*

Declaration for Completion

Theme 1 Learning Environment and Culture
Standards
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Theme 1 Quality Requirements	**Met**	**Partially met**	**Not met**
R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences	All		
R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.	All		

R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.	All		
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	All		
R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.	All		
R1.6 Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.	All		
R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.	All Successful implementation of the 5th Year Assistantship for Newcastle University MBBS teaching programme where students were allocated a designated consultant supervisor.		
R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be	All Posts/programme meet the requirement except those listed in the met and partially met box.	Partially met Student feedback comments on lack of consultant contact, this might be an effect of the ongoing pandemic particularly in community placements or localities with medical workforce recruitment issues. The	

supervised, with closer supervision when they are at lower levels of competence.		students were sufficiently supervised. There have been no student or placement safety issues identified.	
R1.9 Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.	All Posts/programme meet the requirement except those listed in the met and partially met box.	Partially met Linked to R1.8 resulting to reduced patient contact and opportunity to apply skills (for some students) particularly due to the impact of the pandemic and in the North of Tyne where we have higher student numbers. However, this does not impact on patient care.	
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.	All		
R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent.5 Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.	All		
R1.12 Organisations must design rotas to: **a** make sure doctors in training have appropriate clinical supervision **b** support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK **c** provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme **d** give doctors in training access to educational supervisors **e** minimise the adverse effects of fatigue and workload.	All Successful implementation of the 5th Year Assistantship for Newcastle University MBBS teaching programme where students were allocated a designated consultant supervisor and closely worked with the junior doctors within the team		

R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out: **a** their duties and supervision arrangements **b** their role in the team **c** how to gain support from senior colleagues **d** the clinical or medical guidelines and workplace policies they must follow **e** how to access clinical and learning resources. As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.	All		
R1.14 Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.	All As part of the implementation of the 5th Year Assistantships the students participation in the handover process whilst undertaking twilight/out of hours shift.		
R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.	All		
R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.	All Students are also timetabled for self-directed learning sessions		
R1.17 Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.	All		
R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.	All		

R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.	All Posts/programme meet the requirement except those listed in the met and partially met box.	Partially met North of Tyne teaching spaces are not appropriate in relation to design capacity and standard given the student numbers, however, with the opening of the new medical education centre in November 2021 this will alleviate some of the issues once social distancing measures are removed. Capacity will also become an issue in Sunderland from September 2022 when Sunderland medical students will also attend for teaching.	
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	All Newly built education centre incorporates high standard simulation facility.		
R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.	All		
R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.	All		
Theme 2 Educational governance and leadership **Standards** S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met. S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.			

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.			
Theme 2 Quality Requirements	**Met**	**Partially met**	**Not met**
R2.1 Organisations must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.	All		
R2.2 Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.	All		
R2.3 Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.	All		
R2.4 Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.	All		
R2.5 Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.	All		
R2.6 Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.	All		
R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.	All		

R2.8 Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.	All		
R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.	All		
R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.	All All posts/programme meet the requirements with exception of those listed in partially and/not met box	All specified educational roles such as undergraduate lead, LEP lead and SSC lead have dedicated programmed activities. Clinical teachers have the role of teaching within their job plan as part of SPA time but there is not agreed tariff of time. There are ongoing discussion with the Trust finance team looking at aligning funds with quality of teaching activity	
R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.	All		
R2.12 Organisations must have systems to manage learners' progression, with input from a range of people, to inform decisions about their progression.	All		
R2.13 Medical schools must have one or more doctors at the school who oversee medical students' educational progression. They must have one or more doctors at each LEP who coordinate training of medical students, supervise their activities, and make sure these activities are of educational value.	All		
R2.14 and R2.15	*(Not Applicable to Undergraduate Medical)*		

R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.	All		
R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.	All		
R2.18 Medical schools (and the universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.	All		
R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.	All		
R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.	All		
Theme 3 Supporting learners **Standards** S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.			
Theme 3 Quality Requirements	**Met**	**Partially met**	**Not met**
R3.1 Learners must be supported to meet professional standards, as set out in *Good medical practice* and other standards and guidance that uphold the medical	All		

profession. Learners must have a clear way to raise ethical concerns.			
R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including: **a** confidential counselling services **b** careers advice and support **c** occupational health services. Learners must be encouraged to take responsibility for looking after their own health and wellbeing.	All		
R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.	All		
R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010*.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.	All		
R3.5 Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.	All		
R3.6 When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.	All		
R3.7 Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.	All		
R3.8	*(Not Applicable to Undergraduate Medical)*		
R3.9	*(Not Applicable for trust response)*		
R3.10 to R3.12	*(Not Applicable to Undergraduate Medical)*		
R3.13 Learners must receive regular, constructive and meaningful feedback	All Students have end of placement assessment		

on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.	including formative in course assessment that provides feedback. They also receive feedback as part of the supervisors report as part of the assistantship.		
R3.14 Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.	All		
R3.15 Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.	All		
R3.16 Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.	All		
Theme 4 Supporting educators **Standards** S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities. S4.2 Educators receive the support, resources and time to meet their education and training responsibilities			
Theme 4 Quality Requirements	**Met**	**Partially met**	**Not met**
R4.1 Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.	All		
R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.	All		
R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.	All		
R4.4 Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities.	All		

R4.5 Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.	All		
R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.	All		
Theme 5 Delivering and implementing curricula and assessments **Standards** S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates. *S5.2 (Not Applicable to Undergraduate Medical)*			
Theme 5 Quality Requirements	**Met**	**Partially met**	**Not met**
R5.1 Medical school curricula must be planned and show how students can meet the outcomes for graduates across the whole programme.	All		
R5.2 The development of medical school curricula must be informed by medical students, doctors in training, educators, employers, other health and social care professionals and patients, families and carers.	All		
R5.3 Medical school curricula must give medical students: **a** early contact with patients that increases in duration and responsibility as students progress through the programme **b** experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor **c** the opportunity to support and follow patients through their care pathway **d** the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics **e** learning opportunities that integrate basic and clinical science, enabling them to link theory and practice **f** the opportunity to choose areas they are interested in studying while demonstrating the learning outcomes required for graduates **g** learning opportunities enabling them to develop generic professional capabilities	All		

h at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work.			
R5.4 Medical school programmes must give medical students: **a** sufficient practical experience to achieve the learning outcomes required for graduates **b** an educational induction to make sure they understand the curriculum and how their placement fits within the programme **c** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of teachers, before using skills in a clinical situation **d** experiential learning in clinical settings, both real and simulated, that increases in complexity in line with the curriculum **e** the opportunity to work and learn with other health and social care professionals and students to support interprofessional multidisciplinary working **f** placements that enable them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress.	All		
R5.5 Medical schools must assess medical students against the learning outcomes required for graduates at appropriate points. Medical schools must be sure that medical students can meet all the outcomes before graduation. Medical schools must not grant dispensation to students from meeting the standards of competence required for graduates.	All		
R5.6 Medical schools must set fair, reliable and valid assessments that allow them to decide whether medical students have achieved the learning outcomes required for graduates.	All		
R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.	All		
R5.8 Assessments must be carried out by someone with appropriate expertise in the	All		

area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.			
R5.9	*(Not Applicable to Undergraduate Medical)*		
R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through their education and training.	All		
R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.	All		
R5.12 Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the *Equality Act 2010*, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.	All		
HEE Domain 6 Developing a sustainable workforce *(HEE Quality Framework)*			
Domain 6 Quality Standards	**Met** *If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state: 'All placements meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding	All		

other roles and career pathway opportunities.			
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	All		
Declaration of assurance (undergraduate medical section approval) *Sign off from the nominated person, on behalf of the executive team.*			
Name and role: **Date:**	Dr Bruce Owen, Director of Medical Education 28/01/2022		

2.3.2 Undergraduate Medical Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These may include trust wide initiatives as well as departmental / unit examples. Any items listed here will be uploaded to HEEs Good Practice System for sharing across the region. You do not need to duplicate items from the successes section of the SAR (section 1).

	Good Practice Items				
	Item 1	Item 2	Item 3	Item 4	Item 5
What was implemented and why?	CNTW Medical Education Committee Meetings (MEC) to improve communication	CNTW Faculty Development Session on Planning and Implementation of the Assistantships are part of the Newcastle University MBBS Curriculum	CNTW Medical Education Centre with a dedicated simulation based area	Improving contact and communication with medical students. We have developed clinical mentoring sessions within tutor groups which have been valuable in providing support for students during their clinical placements. We have also facilitated drop in sessions where students can drop in to discuss any issues with clinical placements so that necessary interventions can be provided in a timely manner. The mid rotation feedback session	Improving contact and communication with clinicians and educators – we aim to continue to improve our communication with educators and clinicians by providing feedback and updates at consultant meetings and postgraduate teaching sessions.

				allows them to discuss experience/ concerns with undergraduate lead, teaching fellow and admin.	
Profession(s) it relates to	Everyone	Everyone	Everyone	Everyone	Everyone
HEE domain(s) and standard(s) it relates to					
Benefits or positive impact?	This is a new initiative designed to provide an opportunity for the medical education faculty to review outcome of student evaluation/educator feedback at the end of rotations for each year group across all universities. Each undergraduate lead provides a formal report for the year group that is discussed collectively allowing opportunity for sharing good practices across localities in the Trust	It allowed clinicians and educators to be better prepared and increased awareness of intended learning outcomes and structure for delivery of the assistantship. This also included a video for the junior doctors on call whom the students were shadowing so that they knew how to support the students.	State of the art centre with simulation based learning facility	Improving communication with medical students.	Improving communication with educators.
Lessons learned and difficulties encountered	It has been made more inclusive to involve TFs in the membership. No difficulties encountered	None	There have been ongoing challenges with using it due to the Covid 19 pandemic and ongoing social distancing requirements	None	Not every locality has a dedicated consultant meeting for across specialities
Contact for further information (name, role, email, telephone number)	Dr Martina Esisi, Associate Medical Director martina.esisi@cntw.nhs.uk Dr Bruce Owen, DME bruce.owen@cntw.nhs.uk	Dr Martina Esisi, Associate Medical Director martina.esisi@cntw.nhs.uk Dr Nicola Phillips Assistant medical Director nicola.phillips@cntw.nhs.uk	Dr Bruce Owen, DME bruce.owen@cntw.nhs.uk	Dr Martina Esisi, Associate Medical Director martina.esisi@cntw.nhs.uk Dr Nicola Phillips Assistant Medical Director nicola.phillips@cntw.nhs.uk Hannah Adamson Undergraduate Admin Lead	Dr Martina Esisi, Associate Medical Director martina.esisi@cntw.nhs.uk Dr Nicola Phillips Assistant Medical Director nicola.phillips@cntw.nhs.uk Hannah Adamson

				Hannah.adamson@cntw.nhs.uk	Undergraduate Admin Lead Hannah.adamson@cntw.nhs.uk

Please add these and any additional items that you would like to share with the region to the 'Good Practice System' here

2.3.3 Undergraduate Medical Challenges / important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Covid – the impact of covid on teaching which has had to be undertaken using a blended approach due to social distancing rules. For clinical placements, due to the impact of the pandemic there has been a change on the way that services are delivered with new ways of working including remote consultations, greater impact on community placements and less face to face contact with patients for students. There has also been reduced workspace in clinical areas available for students due to the impact of social distancing. This is not seen to be a challenge in terms of patient safety but in terms of creating sufficient suitable clinical learning opportunities for students it has had an impact.		
Sunderland Medical School – the clinical placements for Sunderland Medical School commence in September 2022 and this may have an impact on the number of students in total in that area with the Wear based student. This will also have an impact on available resources and infrastructure. Funding has been identified to cope with the additional demands and there are business and project plans in place to address this with ongoing planning meetings.		

Section 3: Organisational policies and processes in support of delivery of the HEE/GMC Quality Standards and Requirements.

Please copy this section from your last year's SAR and highlight any changes and updates. *Please list policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required. Please advise which domains and standards are being supported by the policy. Please note, we do not require copies of documents. Please do not embed documents or insert links. If required, the quality team will request a copy by exception. Please advise if you have made a reference to a policy/process in other section(s) of the SAR.*

Description of supporting information	**HEE/GMC Domain(s)**	**HEE/GMC Standard(s)**	**Please advise if document referenced in the SAR e.g.** *SAR, section 1.4 and 2.1.1*
"Positive and Safe' Recognition, Prevention and Management of Violence and Aggression Policy CNTW(C)16	1	1.1	
Appraisal, Staff, Policy CNTW(HR)09	1 4	1.2 4.1/4.3./4.4	
Appraisal-Staff-Training-Develop Need Analysis Process PGN - SA-PGN-01 - CNTW(HR)09	1 4	1.2 4.1/4.3./4.4	
Research Governance Policy - CNTW(O)47	1	1.2	
Equality, Diversity and Human Rights Policy - CNTW(O)	1	1.2	
Revalidation, Nursing, Triennial review - Appraisal PGN - SA-PGN-03 - CNTW(HR)09	1 4	1.2 4.1/4.3./4.4	
Induction Policy - CNTW(HR)01	1	1.2	
Dignity and Respect at Work Policy - CNTW(HR)08	1	1.2	
Research Governance Policy - CNTW(O)47	1	1.3	
Learning Lessons - Incident PGN - IP-PGN-05 - CNTW(O)05	1	1.3/1.5	
Audit, Internal, Policy - CNTW(O)25	1	1.3/1.5	
After Action Review (AAR) - Incident PGN - IP-PGN-03 - CNTW(O)05	1	1.3/1.5	
Promoting Engagement with SU's Policy - V03.2 - Issued Dec 17 - CNTW(C)	1	1.4/1.5	
07Promoting Engagement-CYP-PGN-V02 - Issued Dec 17 - PE-PGN-01 - CNTW(C)07	1.	1.4/1.5	
Equality, Diversity and Human Rights Policy - CNTW(O)42	2	2.4	

Equality, Diversity and Human Rights- Impact Assessment PGN - EHDR-PGN-01 - CNTW(O)42	2	2.4	
Safeguarding CNTW(C)24 V04.1	2	2.5	
Adults at Risk and Raising Concerns Policy - CNTW(HR)06	2	2.5	
Safeguarding Children CNTW(C)04 V04.2	2	2.5	
Supporting Staff Involvement in an Incident PGN- IP-PGN-08 - CNTW(O)05	2	2.5	
Induction Policy - CNTW(HR)01	3	3.1/3.2/3.3./3.4/3.5	
Clinical Supervision and Peer Review Policy CNTW(C)31 V05	3	3.1/3.2/3.3./3.4/3.5	
Raising Concerns Policy - CNTW (HR) 06	3	3.1/3.2/3.3./3.4/3.5	
Induction Arrangements for Student Nurses - I-PGN-03 - CNTW(HR)01	3	3.1/3.2/3.3./3.4/3.5	
Study Leave Policy - CNTW(HR)23	4	4.1/4.3./4.4	
Whistleblowing policy (CNTW (HR) 06)	1	1.1	
Supervision of Medical Trainees (Appendix 8 Clinical Supervision Policy CNTW © 31 V06.2	1	1.10	
Continuing Professional Development, Study Leave PGN - SL-PGN-01 - CNTW (HR)23	4	4.1/4.3./4.4	
IP PGN - 08 (Incident policy) Supporting staff involved in an incident V04.			
IP-PGN-06 Part of CNTW(O)05 - Incident Policy			
Clinical Risk Strategy VO1.2 Positive and Safe	1	1.1	
Dignity in Care Policy CNTW(C)40	1	1.1	✓

Section 4: Financial Accountability Report

4.1. Details of Education Contract funding

In this section please describe how the trust has planned and utilised the HEE funding received. Please consider each contract heading. Figures based on Q2 indicative figures.
Useful links:

- *The Government's Education and training tariff guidance and prices for 2021 to 2022 financial year*
- *NHS Education Contract 2021-2024*

Levy	Clinical Group	Contract Heading	21/22 Q1 Funding	Trust Response
Education Support	Other	HEE funded clinician time for HEE work	90,780.00	
Education Support Total			**90,780.00**	
Future Workforce	Non Medical	Placement - Non Tariff	274,934.00	
Future Workforce	Non Medical	Placement - Tariff	1,094,574.00	
Future Workforce	Non Medical	Salary Support - Non Tariff	2,041,155.00	
Future Workforce	Non Medical	Trainee Nurse Associates	31,468.00	
Future Workforce	Postgraduate Medical & Dental	Lead Employer	-72,696.00	LET costs/fees
Future Workforce	Postgraduate Medical & Dental	Placement - Tariff	1,640,160.00	Within CNTW money provided to support medical training is ring-fenced and added to from the trust central funds to form a dedicated Doctors in Training budget. The budget holder for this is the DME which ensures these funds are used to support training and allows a trust-wide flexibility and has been critical in increasing recruitment. Over the reporting year costs in addition to trainee salaries include: Consultant time for leadership roles in PG education including

				DME, AMD and Tutors – 23 sessions - £280K Supervisor time – 140 x 0.5 sessions - £840K Non-medical clinical education salary - £45K Non pay teaching costs £190K Administrative costs: Pay - £170K Non-pay £44K Estates: Hopewood - £34K Jubilee Theatre - £130K Keswick House - £90K (50% as use also for UG) Total - £1,823,000.
Future Workforce	Postgraduate Medical & Dental	Supported Return to Training	2,640.00	Part funds the time for SRT lead employed by the trust at 0.5 PA
Future Workforce	Postgraduate Medical & Dental	Medical Specialist Level ST3+ Higher Training	1,323,504.00	Contributes to salary costs
Future Workforce	Postgraduate Medical & Dental	Medical Specialist Level ST/CT3 core training	357,504.00	Contributes to salary costs
Future Workforce	Postgraduate Medical & Dental	Medical Specialist Level ST/CT2 core training	330,816.00	Contributes to salary costs
Future Workforce	Postgraduate Medical & Dental	Medical Specialist Level ST/CT1 core training	545,664.00	Contributes to salary costs
Future Workforce	Postgraduate Medical & Dental	Medical GP inc RTP GPST2 Hospital	201,096.00	Contributes to salary costs
Future Workforce	Postgraduate Medical & Dental	Medical GP inc RTP GPST1 Hospital	248,112.00	Contributes to salary costs
Future Workforce	Postgraduate Medical & Dental	Medical Foundation Level F2 Trainees	54,720.00	Contributes to salary costs
Future Workforce	Postgraduate Medical & Dental	NEQOS	9,000.00	
Future Workforce	Undergraduate Medical & Dental	Placement - Tariff	2,008,112.00	
Future Workforce Total			**10,090,763.00**	

National Activities	Other	AHP workforce transformation	0.00	
National Activities	Other	ICA Programme	5,456.00	
National Activities	Other	C-19 Recovery DME funding	60,000.00	
National Activities Total			**65,456.00**	
Workforce Development	(blank)	Nursing CPD 50% Annual Allocation	440,333.00	
Workforce Development Total			**440,333.00**	
Grand Total			**10,687,332.00**	

4.2. Additional in year funding already provided

In this section please list any additional funding received from HEE, for example any regional or national funding received outside of the Education Contract payments. Please state the amount received, provide a high-level description of what this additional funding is for and please describe how the trust has utilised this funding.

Funding Amount	High level description	Please describe how the trust has used this funding including any impact and considerations for future work

4.3. Use of funding to support Staff and Specialty Doctors (SAS) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required.

Questions	Trust's answer
Number of SAS doctors within the trust	**86**
Total SAS funding received	**£26,000**
Is the SAS funding ring-fenced to support SAS doctors only? (Y/N)	**yes**
Please describe the process by which the development needs of SAS doctors within your organisation were individually and collectively identified. Using funding allocated for SAS development; How were priorities decided?	Several years ago, it was agreed by the SAS group that the money would be used to facilitate whole group SAS CPD sessions (our 4x yearly SAS Forum). We have a regular business meetings at each SAS Forum and discuss collectively the needs of the group and CPD topics we can include at future meetings that will benefit as many of the group as

Any plans or initiatives to respond to the GMC SAS/LED survey findings?	possible. For this reason, we tend to focus on generic topics rather than anything too specific to particular subspecialties. SAS Charter has been implemented in the trust. SAS/LED findings have been circulated, but no specific actions taken. Any local issues regarding SAS can be discussed in SAS Business meeting, SAS doctors are also represented at LNC Over the reporting year the forum has met remotely leading to a reduction in costs. Discussion with the current SAS tutor regarding outstanding funds due to this have led to a decision to use this funding to purchase educational resources for SAS doctors
SAS nominated lead within the trust	**Dr Victoria Thomas for reporting period but now Dr Marcin Ostrowski**

Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)

	Spending	**Detail**
1. Individual doctor's development (i.e. details of spending used to support the development of individual doctors including an anonymised list of amounts and what it was used for)		MHA tribunal simulation been delivered free of charge to 9 SAS doctors
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered)	£1000	SAS Doctor forums 06/10/20 – no costs involved 21/01/21 – no costs involved 22 & 22/04/21 - £1,000.00 fee for Carole Burrell, Lecturer in Law, Northumbria University 08/07/21 – no costs involved
3. Payment for SAS tutors/leads sessions		1PA
4. Administrative costs to support SAS tutors		0.5 of band 3 admin support
5. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)		9K outstanding with plan to spend on educational resources