Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

1 November 2023

13:30 GMT Europe/London

Trust Board Room and via Teams

AGENDA

1. AGENDA

Darren Best, Chairman

REFERENCES

Only PDFs are attached

BoD Agenda Public November 2023 DRAFT 003 DH.pdf

Board of Directors PUBLIC Board Meeting Agenda

Board of Directors PUBLIC Board meeting **Venue: Trust Board Room, St Nicholas Hospital and via MS Teams**	**Date: Wednesday 1 November 2023** **Time: 1:30pm– 3:30pm**

	Item	Lead	
1.1	Welcome and Apologies for Absence	Darren Best, Chairman	Verbal
2	Service User / Carer / Staff Journey	Guest Speaker	Verbal
3	Declarations of Interest	Darren Best, Chairman	Verbal
4	Minutes of the meeting held 4 October 2023	Darren Best, Chairman	Enc
5	Action Log and Matters Arising from previous meeting	Darren Best, Chairman	Enc
6	Chairman's Update - Vice Chair	Darren Best, Chairman	Verbal
7	Chief Executive Report	James Duncan, Chief Executive	Enc
Quality, Safety and patient issues			
8	Integrated Performance Report (Month 6)	Ramona Duguid, Chief Operating Officer	Enc
9	Annual Safety, Security and Resilience Report 2022/23 (including EPRR Report Core Standards Assessment)	Ramona Duguid, Chief Operating Officer	Enc
10	Safer Care Report	Rajesh Nadkarni, Deputy Chief Executive / Medical Director	Enc
11	CQC Must Do Report update	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc

12	Quality Priorities update (Quarter 2) Report	Ramona Duguid, Chief Operating Officer	Enc
13	Patient Safety Incident Response Framework Plan	Rajesh Nadkarni, Deputy Chief Executive / Medical Director	Enc
Workforce issues			
14	Equality, Diversity and Inclusion Improvement Plan	Lynne Shaw, Executive Director of Workforce and OD	Pres
15	Guardian of Safe Working Report	Rajesh Nadkarni, Deputy Chief Executive / Medical Director	Enc
16	16.1 Raising Concerns – Whistleblowing Report 16.2 Freedom to Speak Up Reflection Tool and Action Plan	Lynne Shaw, Executive Director of Workforce and OD Lynne Shaw, Executive Director of Workforce and OD	Enc Enc
17	International Recruitment update	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	
Regulatory / compliance issues			
18	NHSE/I Single Oversight Framework Compliance Report	Ramona Duguid, Chief Operating Officer	Enc
19	Infection Prevention and Control (IPC) Board Assurance Framework	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc
20	Board Assurance Framework 2023	Debbie Henderson, Director of Communications and Corporate Affairs	Enc
21	Board Committee Annual review against Terms of Reference 2023	Debbie Henderson, Director of Communications and Corporate Affairs	Enc
Strategy, planning and partnerships			

22	**Integrated Care System (ICS) – system issues:** **22.1 North East and North Cumbria Provider Collaborative Governance** **22.2 ICS Joint Forward Plan**	**James Duncan, Chief Executive**	**verbal**
23	**Finance Report**	**Kevin Scollay, Executive Director of Finance**	**Enc**
Committee updates			
24	**Quality and Performance Committee**	**Louise Nelson, Chair**	**verbal**
25	**Audit Committee**	**David Arthur, Chair**	**verbal**
26	**Resource and Business Assurance Committee**	**Paula Breen, Chair**	**verbal**
27	**Mental Health Legislation Committee**	**Michael Robinson, Chair**	**verbal**
28	**Provider Collaborative Committee** *No meeting held during the period*	**Michael Robinson, Chair**	**N/A**
29	**People Committee**	**Brendan Hill, Chair**	**verbal**
30	**Charitable Funds Committee**	**Louise Nelson, Chair**	**verbal**
31	**Council of Governors' Issues**	**Darren Best, Chairman**	**Verbal**
32	**Questions from the Public**	**Darren Best, Chairman**	**Verbal**
33	**Any other business**	**Darren Best, Chairman**	**Verbal**

Date and Time of Next Meeting:

Wednesday 6 December 2023
1:30pm – 3:30pm
Trust Board Room, St Nicholas Hospital and via Microsoft Teams

1.1 WELCOME AND APOLOGIES FOR ABSENCE

Darren Best, Chairman

2. SERVICE USER / CARER / STAFF STORY

Guest Speaker

3. DECLARATION OF INTEREST

Darren Best, Chairman

4. MINUTES OF THE MEETING HELD 4 OCTOBER 2023

Darren Best, Chairman

REFERENCES

Only PDFs are attached

4. Public Minutes 4 October 2023 FINAL DRAFT.pdf

Minutes of the Board of Directors meeting held in Public
Wednesday 4 October 1.30pm – 3.30pm
Trust Board Room, St Nicholas Hospital and via MS Teams

Present:
Darren Best, Chair
David Arthur, Senior Independent Director/Non-Executive Director
Brendan Hill, Non-Executive Director
Michael Robinson, Non-Executive Director
Louise Nelson, Non-Executive Director

James Duncan, Chief Executive
Rajesh Nadkarni, Deputy Chief Executive / Medical Director
Ramona Duguid, Chief Operating Officer
Kevin Scollay, Executive Director of Finance
Lynne Shaw, Executive Director of Workforce and Organisational Development

In attendance:
Debbie Henderson, Director of Communications and Corporate Affairs
Anthony Deery, Deputy Director of Nursing
Jack Wilson, Corporate Engagement Assistant
Ruth Berkley, Appointed Governor for South Tyneside (on-line)
Margaret Adams, Chair of the Service User and Carer Reference Group
Evelyn Bitcon, Public Governor for North Cumbria
Emma Silver-Price, Non-Clinical Staff Governor
Chris Rowlands, Lead for Equality, Diversity and Inclusion
Sampson Umeaku, Nursing Assistant
Dr Mawada Adam, Consultant Psychiatrist

1. Welcome and apologies for absence

Darren Best welcomed everyone to the meeting and apologies received from Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance and Paula Breen, Non-Executive Director.

2. Declarations of interest

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

3. Service User/Carer Story/ Staff Journey

Due to unforeseen circumstances, there was no service user journey update at this meeting.

4. Minutes of the meeting held 6th September 2023

The minutes of the meeting held on 6th September 2023 were considered and agreed with a minor amendment to include Brendan Hill's apologies for absence.

Approved:
- **The minutes of the meetings held 6th September 2023 were approved subject to the amendment to attendance.**

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

There were no outstanding items to note.

6. Chairman's update

At his first Board meeting as Chair, Darren Best acknowledged the contribution made by Ken Jarrold prior to his retirement. Darren noted the confidence of the Non-Executive in the Executive Team in the context of the challenges faced by the Trust, while recognising the need for robust and clear plans on the actions being taken to address the challenges.

Darren referred to 10 things that make CNTW special previously referenced by Ken Jarrold emphasising the strength of the Trust as an organisation which does not have complacency. Darren reflected on the interview process for his appointment as Chair and outlined the four key challenges for the Trust and his role as Chair in maintaining a focus on these going forward. The four challenges are how will CNTW lead and help provide high quality, safe and timely mental health services, how will CNTW retain, develop, and continue to attract the very best people, what kind of organisation does CNTW need to be and who do we need to engage and work with to deliver, and how do we afford this and ensure financial sustainability.

Resolved:

- **The Board received the Chair's update.**

7. Chief Executive's Report

James Duncan referred to the Chief Executive's report and noted three further updates. James referred to national coverage of the current position of the NHS in terms of the financial and operational challenges faced noting that all Integrated Care Systems across the country have confirmed their inability to meet financial plans. Discussions are taking place between the NHS and the Treasury around next steps. In this context, James reflected on the four key challenges for the Trust outlined by Darren earlier in the meeting stating that collaborative working with system partners will be key to our ability to deliver our strategic ambitions.

James reflected on the Annual Staff Excellence Awards held on 30th September. James acknowledged the 350 people in attendance who were nominated for their outstanding care and work across many services, both clinical and non-clinical across the Trust and its subsidiary company NTW Solutions Limited.

Resolved:

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

Quality, Clinical and Patient Issues

8. Monthly Integrated Performance Report (Month 5)

Ramona Duguid referred to the report noting improved performance relating to 72-hour follow up and a decrease in the number of patients clinically ready for discharge. Ongoing challenges remain in relation to out of area placement with 13 in month 5, however Ramona advised that as at the time of the meeting, this number had reduced to 6. The Board acknowledged the significant amount of work undertaken to get to this position.

Ramona stated that detailed work has commenced to address the challenges around Crisis services including a review of the Crisis model, improving the 136-suite flow, developing alternatives to admission and interface with community services. challenges. A recovery plan is being implemented for the North Cumbria locality.

Ramona referred to the challenges relating to Psychiatric Liaison Teams, particularly for the Central and North localities. A report on the outcomes from an intensive piece of work will be taken to the October meeting of the Quality and Performance Committee.

The Quality and Performance Committee continued to receive monthly reports on waiting times and Ramona noted an improved position with the exception of the North Cumbria locality. Children and Young People's waiting times continues to be escalated for discussion with an input from, the North East and North Cumbria Integrated Care Board (NENC ICB) and the Trust are engaging in rapid improvement workshops with a view to developing system-wide recommendations.

Anthony Deery provided an update on the section on commitments to carers and patients noting a reduction in the number of positive responses in relation to the friends and family test question, and

people feeling the information they are provided with is helpful. Whilst standards for all measures relating to carers and patients are not being met, there has been improvement in all areas for the period. In terms of mitigating actions, operational teams have been encouraged to use Points of You, and receive support to use the PoY dashboard, service user and carer involvement is embedded within all locality governance processes. There has been a refresh of the Carers training and the Carers Promise as been relaunched.

Lynne Shaw provided an update on the 'Great Place to Work' section of the report noting a decrease in the percentage of clinical supervision across all areas during the period. An improved position was noted in relation to sickness, training compliance, and appraisal rates. A review of Training Needs Analysis requirements has commenced to ensure training requirements are aligned to appropriate professions and roles. Darren Best referred to the plethora of training needs for staff and asked for an update to be provided to the People Committee on areas of priority to ensure training requirements are not overwhelming for staff. Margaret Adams also suggested defining the impact of training and its correlation to the appraisal process in terms of providing the tools needed to enable people to deliver services safely and effectively.

Evelyn Bitcon referred to concerns were raised regarding performance issues in the North Cumbria locality at the July meeting of the Governors' Quality Group and a subsequent meeting to discuss concerns. These included the lack of PALs service in the region, lack of information on Trust services in Primary Care, lack of progress since the transfer of services and the future of services in region. James advised that a significant amount of work had been undertaken in the North Cumbria locality involving many services, staff, and service users. James referred to a forthcoming meeting with Healthwatch to discuss how to improve engagement across the Cumbria locality. Ramona Duguid advised that discussions were ongoing regarding the development of urgent and inpatient services in North Cumbria as part of a newly established Partnership Board attended by all Place-based representatives.

Ruth Berkley queried whether the Trust had seen an increase in activity relating to urgent cases linked to the cost-of-living crisis. James advised that it would be difficult to evidence but suggested that the cost-of-living crisis would likely have impacted all health and care services including the NHS, the community and voluntary sector and other organisations. There is evidence that it is impacting on transient mental health issues, but less clear evidence about chronic and severe mental illness. What we have seen is significant increases in referrals across Children and young people's services but more stability in adult referrals. Discussions are taking place at the NENC ICS Leadership Group around the best way to respond to health issues resulting from social and environmental impact. A caveat to this is to avoid over-medicalising and over-prescribing while providing such support. The Trust's work on community transformation aims to ensure people have the right support for their needs in the right place.

Resolved:

- **The Board received the monthly Integrated Performance Report (Month 2).**

Action:

- **Briefing to be provided to the People Committee on the Training Needs Analysis review and summary of training requirements for all designations of staff**

9. Winter planning update

Ramona Duguid referred to the report which provided an update on the winter planning process for 2023/24 in line with NHSE guidance and actions to be taken as a system to meet the challenges ahead. The guidance focusses on supporting acute Trusts and the key steps to help achieve the ambitions for urgent and emergency care recovery outlined in the report.

Resolved:

- **The Board received the Winter Planning update**

Workforce updates
There were no updates scheduled for the period.

Regulatory / Compliance updates
There were no updates scheduled for the period.

Strategy, planning and partnerships updates

10. Integrated Care System (ICS) / Integrated Care Board (ICB) update
James Duncan advised of the establishment of an NENC ICS System Leadership Board. A development session was held to discuss priorities to achieve the aims and ambitions of the NENC ICB Strategy. James advised that supporting Children and Young People's (CYPs) mental health was identified as a key priority for the system. A system wide CYPS summit will be held on 25th October to discuss this priority further.

11. Finance Report
Kevin Scollay advised of a £10.9m deficit position for the Trust year to date. This represented a £0.1m improved position against the financial plan submitted to NHSE at Month 5. The plan is phased to deliver deficits in the first 6 months of the year and surpluses for the second half of the year. Agency costs were above the agency ceiling and planned levels. Expenditure on the Trust capital programme was £1.4m lower than planned at Month 5, which is a reduced underspend in month. The Trust is forecasting to deliver against plan for the year. This position remains under review.

Resolved
- **The Board received and noted the Finance Report.**

Key Item for Discussion

12. CNTW Cultural Celebration Events
Sampson Umeaku and Dr Mawada Adam delivered a presentation to the Trust on the Cultural Celebration events held across the Trust since February, commencing with a pilot event in Roselodge in February. Two further events took place at St George's Park and Hopewood Park. The aim of the event was to celebrate the diverse workforce and to promote inclusivity. A discussion took place on the benefits of the events which included the promotion of diversity across the Trust, cultural understanding and awareness, their role in fostering a sense of unity and community and improved staff morale and wellbeing.

The Board thanked Sampson, Mawada, Chris Rowlands and Emma Silver-Price for their successful implementation of the events which contribute towards the organisation's commitment to the equality, diversity and inclusion agenda, and gave their support for the continuation of further events.

Board sub-committee minutes and Governor issues for information

13. Quality and Performance Committee
Darren Best referred to the September meeting of the Committee highlighting the discussion on the Integrated Performance Report and continued focus on waiting times. A discussion took place on the Safer Staffing Report which will be further reviewed prior submission to Quality and Performance Committee and Board. Consideration will be given to how assurance can be provided in the absence of a safer staffing report in the meantime, in the context of providing safe services.

14. Audit Committee
No meeting taken place during the period.

15. Resource and Business Assurance Committee
No meeting taken place during the period.

16. Mental Health Legislation Committee

No meeting taken place during the period.

17. Provider Collaborative Committee

Michael Robinson referred to the ongoing review of adult secure services with the results to be reported to the December meeting of the Committee. The position of adult secure services remains challenging, particularly around repatriation of service users and out of area placements. The December meeting will also receive the report prepared following Commissioner Oversight visits to the Tees, Esk and Wear Valley NHS FT operated secure services which were undertaken in co-ordination with the ICB. The December meeting will also further discuss the governance role of the Committee.

18. People Committee

No meeting taken place during the period.

19. Charitable Funds Committee

No meeting taken place during the period.

20. Council of Governors issues

There were no issues to report for the period.

21. Any Other Business

There were no further issues to report.

22. Questions from the public

There were no questions from the public.

Date and time of next meeting

Wednesday, 1 November 2023, 1:30pm at Trust Boardroom, St Nicholas Hospital and online via Microsoft Teams.

5. ACTION LOG AND MATTERS ARISING FROM PREVIOUS MEETING

Darren Best, Chairman

REFERENCES

Only PDFs are attached

5. BoD Action Log PUBLIC at 1 Nov 2023.pdf

Board of Directors Meeting held in public

Action Log as at 4 October 2023

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					
02.08.23 (8)	Integrated Performance Report	A focussed discussion on Psychiatric Liaison Referrals to be undertaken	Ramona Duguid/ Rajesh Nadkarni	November 2023	
05.07.23 (7)	CE Report	Discussion on the Institute for Public Police Research Health and Care Workforce Assembly report to be undertaken at a future Board meeting	James Duncan	TBC	
06.09.23 (8)	Integrated Performance Report	A detailed update on the impact of the Right Care Right Person model to be provided to a future meeting of the Quality and Performance Committee	Sarah Rushbrooke	October 2023	
Completed Actions					
05.07.23 (12)	CQC Must Do Report	Updated report to include fundamental actions with older actions reporting to Quality and Performance Committee	Sarah Rushbrooke	September 2023	Complete – agenda item for September's meeting

6. CHAIRMAN'S UPDATE

Darren Best, Chairman

• Vice Chair

7. CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

7. CEO Report to Board of Directors November 2023 v2.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**Chief Executive's Report**
Executive Lead	**James Duncan, Chief Executive**
Report author	**Jane Welch, Policy Advisor to the Chief Executive**

Purpose of the report	
To note	**X**
For assurance	
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

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

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience		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 1st November 2023

Trust updates

Treating Tobacco Dependency in Mental Health Conference

CNTW held its first Treating Tobacco Dependency in Mental Health Conference in October. The conference aimed to support the shifting of staff attitudes and behaviour towards smoking and the treatment of tobacco dependency, promoting the importance of this as a chronic, relapsing medical condition requiring treatment as part of routine medical care.

Highlights of the day included impactful presentations from speakers including Dr Debbie Robson from Kings College London; Mary Yates from the National Centre for Smoking Cessation Training; Dr Alan Curley from UC Mind Solutions Ltd; Dr Ruth Sharrock respiratory consultant at Gateshead Health NHS Foundation Trust and Clinical Lead for Tobacco Dependency for the North East and North Cumbria Integrated Care Board (NENC ICB); and the North East North Cumbria smokefree taskforce including Ailsa Rutter, Director of Fresh. The event was chaired by Dr Guy Pilkington, Chair of the NENC ICB Prevention Board.

A range of topics were covered including the prevalence of smoking rates for people with severe mental illness, the physical and mental harms caused by smoking, supporting patients with severe mental illness to quit, evidence of vaping as a successful mechanism to support patients to reduce their tobacco dependency, and the showcasing of a variety of work around tobacco dependency across the trust including QUIT team, community treatment teams and smoking and dementia. Providing support to staff for their tobacco dependency was also highlighted as a key area for action. To conclude the conference James Duncan and staff signed up to the Fresh declaration for a Smokefree future. Next steps following the conference include presenting proposals for action at the Trust's Executive Management Group and wider discussions with the Trust's Leadership Forum.

Photo: Trust Chief Executive James Duncan and staff signing the Fresh declaration.

Health and Safety Executive visit

The Health and Safety Executive (HSE) started their inspection of the Trust this week spending a day with us to understand more about the organisation and gain a much greater insight into Trust leadership, governance arrangements, and our response to their report on Violence and Aggression and Musculoskeletal Disorders (MSD). They will also be exploring our journey of safety and some of the challenges facing the NHS locally and nationally.

We now await further communications from HSE inspectors about plans for a two-day inspection expected to take place between November 2023 and March 2024. The inspection will focus on Mitford due to its incident/RIDDOR profile and limited capacity to undertake a wider inspection, however HSE inspectors will also visit the new Sycamore unit to understand our environmental approach and see some of the systems already discussed with them. Inspectors will also speak to managers and review their safety information and training records, with a focus on aggression and violence and potentially musculoskeletal disorders. The Centre for Aging and Vitality (CAV) has also been identified for a site visit during day two of the inspection, as this will provide an opportunity to review musculoskeletal disorders among older people on Akenside and Castleside wards, and violence and aggression at Hadrian Clinic.

Further information will be provided to the Board once the two-day inspection has been confirmed.

Triangle of Care Annual Report 2023

To retain Triangle of Care accreditation, the Trust must continue to align with Triangle of Care standards at a service and organisational level. The Triangle of Care Annual Report 2023 was submitted to the Carers Trust to demonstrate performance and highlight key areas of achievement, showing how they align with the Triangle of Care standards.

The outcome of the Carers Trust assessment found that there is clear support for the delivery of the Triangle of Care at all levels of the Trust highlighted in the Governance Structure, including Triangle of Care locality meetings which feed into this structure, and also through the Involvement and Experience Oversight Group and the Carers Together Advisory Group. It was noted that CNTW have clearly set out that the Triangle of Care also relates to those using our services through five specific commitments (Carer Promise), that work continues to embed Triangle of Care and meet the standards with all localities increasing their ratings from 2022, and that carers are well represented in the Involvement Bank. Externally, Carers Trust welcomed the clear commitment to engage and be transparent with carers connected through the Trust via the Carer Conference and activities in Carers Week and Young Carers Action Day.

The annual report was found to be clear and honest, highlighting engagement at all levels of the Trust, as well as defining clear actions for the future. The Trust successfully retained 2-star accreditation status.

Aspiring Mental Health Nurse Directors Programme 2023

Two CNTW Associate Nurse Directors have been selected to participate in the NHS Confederation's Aspiring Mental Health Nurse Directors Programme 2023 following a

competitive application process. The Aspiring Mental Health Nurse Directors Programme is a development programme featuring four masterclasses, peer support meetings and one-to-one coaching. Seventeen candidates will participate in the 2023 programme, which equips aspiring leaders with the knowledge, tools and insight to progress to a nursing director role. Participants will benefit from peer support and practical advice and guidance until they interview for nursing director posts, as well as expanding their professional network and connecting with peers across the country.

Regional updates

Women's Health Strategy Implementation Plan

The North East and North Cumbria Integrated Care Board (NENC ICB) are developing a North East and North Cumbria Women's Health Programme to take forward the implementation of the national Women's Health Strategy for England, published in August 2022. The regional implementation plan will be focused on the strategy's seven priorities:

1. Menstrual health and gynaecological conditions
2. Fertility, pregnancy, pregnancy loss and post-natal support
3. Menopause
4. Mental health and wellbeing
5. Cancers
6. The health impacts of violence against women and girls
7. Healthy ageing and long-term conditions

A joint North East North Cumbria Women's Health Conference with the Office for Health Improvement and Disparities was held during October to showcase best practice from across the region, identify improvement priorities, and support the collaborative development of the implementation plan.

North East Devolution and Integrated Care Partnerships

Following a successful consultation period a new devolution deal has been agreed and a new North East Combined Authority will be established which will cover Northumberland, North Tyneside, Newcastle, Gateshead, County Durham, South Tyneside and Sunderland. This will replace the existing North of Tyne Combined Authority which covers Newcastle, Northumberland, and North Tyneside. The Integrated Care Board is engaging with the team supporting the transition to the new combined authority on a range of issues including health inequalities, public health, and work and health and will be the NHS representative for this work, engaging with local NHS partners as this work progresses. Proposals are currently being developed to align the North and Central Integrated Care Partnerships to the new Combined Authority footprint, and will be presented to the next regional Integrated Care Partnership for consideration.

"Always the Right Door" A Children's and Young People's Mental Health Summit

The North East and North Cumbria Health and Care Partnership ran a summit on 25th October exploring the current state of support for children and young people across the North East and North Cumbria and opportunities for improvement. This coincided with the launch of Boost, the Improvement Network for the system. The event was attended by service users and carers and representatives from organisations from across the system. An interactive and rapid approach to identifying opportunities for improvement was utilised, and collective priorities agreed. These are currently being collated for dissemination and will be shared with the Board when available. Leaders from across the system pledged to make improving our approach to supporting children, young people and their families a priority and to take forward the learning and the actions from the day.

National updates

NHS England health inequalities frameworks

NHS England published two new frameworks to support work to reduce health inequalities.

Inclusion Health Framework

The Inclusion Health Framework provides practical information to support NHS systems and their partners to take practical action on reducing health inequalities for inclusion health groups, such as people experiencing homelessness and Gypsy, Roma, and Traveller communities. The Framework is focused on the role of the NHS in improving healthcare and is based on five principles:

1. Commit to action on inclusion health.
2. Understand the characteristics and needs of people in inclusion health groups.
3. Develop the workforce for inclusion health.
4. Deliver integrated and accessible services for inclusion health.
5. Demonstrate impact and improvement through action on inclusion health.

Digital Inclusion Framework

The Digital Inclusion Framework supports the design and implementation of inclusive digital approaches and technologies. It identifies five domains where action is needed:

1. Access to devices and data, so that everyone who wants to can access digital healthcare.
2. Accessibility and ease of using technology, so that digital products are co-designed and improve patient outcomes.
3. Skills and capability, so that everyone can use digital approaches.
4. Beliefs and trust, so that people understand and feel confident using digital health approaches.
5. Leadership and partnerships, so that digital inclusion work is coordinated and addresses health inequalities.

Premature mortality among people with SMI during the pandemic

The Office for Health Improvement and Disparities (OHID) published a new analysis of premature mortality among people with SMI during the pandemic:

- The North East had one of the highest excess premature mortality rates for people with SMI, suggesting that although premature mortality during the pandemic impacted the whole population, its effect on those with SMI was even greater.
- The excess premature mortality rate in people with SMI in the North East during the pandemic was 438%.
- The report suggests several potential causes of premature mortality among people with SMI during the pandemic – alcohol-related liver disease due to increased alcohol consumption; cancer, respiratory disease, and cardiovascular disease – there were delays in cancer diagnosis among the general population and people with SMI have a high prevalence of risk factors for disease including smoking and obesity; and issues accessing primary and secondary care services.
- People with SMI have increased vulnerability to changes in economic circumstances and the impact of climate change and should be given special consideration in pandemic and major incident planning.
- Service commissioners and providers should take steps to ensure this, for example, by securing access to healthcare for people with SMI during lockdowns, considering people with SMI as a priority group for vaccination during pandemics and disease outbreaks, and mitigating the risks of extreme hot or cold weather to the health and wellbeing of people with SMI.

CQC State of Care report 2022/23

The Care Quality Commission (CQC) published its annual State of Care report examining the quality of health and care services in England over the past year. Key points include:

- The cost-of-living crisis and escalating workforce pressures risk the development of a two-tier health and care system where those who can afford to pay for private treatment do so and those who can't face longer waits and reduced access to health and care services.
- Social care providers are facing increased running costs and wages in the sector are struggling to keep up with inflation, impacting on quality of care and providers ability to reinvest in care homes – the profitability of care homes remains at historically low levels.
- Local authority budgets have failed to keep pace with rising costs, and as LA-funded social care places are often less profitable there is a risk that people living in more deprived areas may not be able to get the care they need.
- Access to and quality of mental health care remain a key area of concern. Gaps in community care continue to put pressure on mental health inpatient services, with many inpatient services struggling to provide a bed, which in turn leads to people being cared for in inappropriate environments. Safety continues to be an area of

concern, with 40% of mental health providers rated as requires improvement or inadequate for safety.

Royal College of Psychiatrists report on infant and early childhood mental health

The Royal College of Psychiatrists published Infant and Early Childhood Mental Health: the case for action, which calls on the Government to prioritise the mental health of babies and young children. Key points include:

- The childhood early years (preconception to 5 years) are a critical period for brain and psychological development, the formation of enduring relationship patterns, and emotional, social and cognitive functioning, all of which are foundations for healthy development and can be protective against mental health conditions.
- Despite the existence of evidence-based public mental health interventions, only a minority of under 5s with mental health conditions are identified or receive treatment, with negligible coverage of interventions to prevent mental health conditions or promote mental wellbeing and resilience.
- Only a minority of parents during pregnancy or with children under 5 years receive interventions to prevent or treat mental health conditions.

The report sets out a series of recommendations for improving infant and early childhood mental health, including the development of a cross-government strategy for the mental health of the under 5s and investment in resources and workforce training to deliver an agreed population scale, sustainable, integrated, multi-agency stepped care approach to mental health of under 5s.

Public services investment vs. public services reform

The Institute of Public Policy Research (IPPR) published 'The Smarter State: Between the 'Magic Money Tree' and the 'Reform Fairy'', a report which argues that policymakers will have to combine both investment and reform approaches to solve the UK's public services performance crisis. Key points from the report include:

- Performance - in terms of access, quality and experience - across many public services is worse now than in 2010 and is lagging behind best practice abroad.
- Policymakers will need to combine both funding and reform to create a smarter state to solve the crisis, and deliver progress towards prevention, personalised services, and improved productivity.
- The New Public Management (NPM) approach is flawed. NPM assumes that public services fail to innovate because of the absence of market forces which lead to weak or misaligned incentives. Reforms aiming to correct this include importing private sector practices (e.g. targets) and the introduction of quasi-markets (e.g. choice).
- NPM is based on the idea that staff and service users in public services require rewards and punishment to drive behaviour change, whereas evidence increasingly suggests that intrinsic motivation is a stronger driver of behaviour change in many circumstances.

- In contrast to the low trust, low skill and low autonomy model associated with top-down targets, regulation, financial incentives, choice and competition, the UK needs to shift to a high trust, high skill, high autonomy model characterised by shared missions, devolution of power to the frontline, investment in skills/capabilities, peer-to-peer learning and empowerment of citizens. The report sets out some of the reforms needed to deliver this.

8. INTEGRATED PERFORMANCE REPORT MONTH 6

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

8. Board Cover Sheet - IPR - Month 6.pdf

8. IPR Trust Report - Month 6 2023.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**Integrated Performance Report Month 6**
Executive Lead	**Ramona Duguid, Chief Operating Officer**
Report author	**Tommy Davies, Head of Performance and Operational Delivery**

Purpose of the report	
To note	
For assurance	**X**
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

Meetings where this item has been considered	
Quality and Performance	25.10.23
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
People	
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	23.10.23
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience	X	Service user, carer and stakeholder involvement	X

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

SA1 Quality care, every day – We want to deliver expert, compassionate, person-led care
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. (SA1)

SA2 Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals.
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. (SA2)

SA3 A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.
Risks 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. (SA3)

SA4 Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled**.**
Risk 1762 Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments. (SA4)

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2023-24 Month 6 (September 2023)

With YOU in mind

Integrated Performance Report - Headline Commentary

Headline Challenges

- **Commitments to our Carers & Patients –** Three of the five patient satisfaction measures consistently below standard.
- **% of Training Compliance (Courses with a standard) –** Only 9 of 27 courses on target, this has improved over the last year.
- **Serious Incidents -** Despite the low numbers, the incidents are of serious magnitude, so an exception report is included.
- **CPA Completed Review –** Off target, 86.8% against a 95% standard, however, there has been an uptick of 7% this month and the last 4 months have improved.
- **Out of Area Placements/Clinically Ready for Discharge/ Bed Occupancy -** All remain reported off track (Month 5)
- **Crisis Very Urgent Referrals seen within 4 hours –** At 39.4%, very low referral numbers means performance fluctuates significantly.
- **Psychiatric Liaison Referrals in ED within 1 hour –** Significant improvement in the month but lower than peers. The performance in North is not as positive as other localities.
- **4-week national standard waiting times targets are reported in this month's report, this was introduced in July 23.**
    - **% waiting < 4 weeks to Treatment Adult and Older Adult Waits to Treatment** – 24.6% of referrals have been waiting 4 weeks or less to treatment.
    - **% waiting < 4 weeks to Receive Help - All CYPS** – 9.5% of referrals have been waiting 4 weeks or less to receive help.
    - **% waiting < 4 weeks to Receive Help - CYPS Neuro Developmental** – 6.2% of referrals have been waiting 4 weeks or less to receive help.
- **Live within our means –** 23/24 forecast under significant pressure. Trust financial position shows marginally better than plan at month 6. Plan includes phasing adjustment to reflect phasing of efficiencies.

Key focus areas of concern

- **% of Training Compliance (Courses with a standard)**
- **Crisis Very Urgent Referrals seen within 4 hours**
- **Psychiatric Liaison Referrals in ED seen within 1 hour**
- **% waiting < 4 weeks to Treatment – Adult and Older Adult waits**
- **% waiting < 4 weeks to Receive Help – All CYPS & CYPS Neuro Developmental waits**
- **Live within our means**

Positive Assurance / Improvement

- **EIP (Early Intervention Psychosis) -** consistently above standard.
- **72 hour follow up -** remains consistently above the 80% standard.
- **CYPS Eating Disorders (Urgent Referrals) -** is on target this month
- **Eating Disorder Routine** – significant improvement in the month, the highest reported % in 24 months
- **CPA Completed Review –** 7% improvement in the month
- **Risk Assessment** – Met standard for the first time in 15 months
- **Aggression and Violence** - Activity has been reported at the lowest level within this financial year, against a backdrop of overall incident increase for the month of September.
- **Long term segregation and seclusion** – Reduced again this month. Positive outcomes for a service user who has recently come out of Long term segregation.
- **Out of Area Placements –** As at 16-10-23 there are no inappropriate Out of Area Placements.
- **Psychiatric Liaison Referrals in ED within 1 hour and 24hr on wards**– Both measures showing significant improvement in month

Mitigations/actions

- **% of Training Compliance (Courses with a standard) –** The improvement work is being managed through the (BDG) Business Delivery Group – Workforce. Localities and Corporate Services have been tasked with setting trajectories to improve performance in the next two quarters. The full breakdown of courses is available on page 23 of this report and is available in the Locality versions of the Integrated Performance Report for monitoring at Group Directorate level.
- **Crisis Very Urgent Referrals seen within 4 hours -** Locality recovery actions are being reviewed alongside the data at the Access Oversight Group. There is also a working group to review the effectiveness of the implementation of the new standards for Crisis including, improving the processes and recording. A new Crisis Model is being developed as part of the Urgent Care and Inpatient Programme. This will involve, improving the 136 suite flow, developing alternatives to admission, community interface, discharge model/in-reach and the development of 111 for Mental Health. *Recovery plans in place*
- **Psychiatric Liaison Referrals in ED within 1 hour -** Urgent and Emergency sub-group of the Access and Oversight group has been reinstated to focus on improvement. Also, TIG supported by a Clinical Lead have reviewed practices and supported improvement across all Localities. There have been a large uptick in performance of 7.4% to 63.4% this month because of this focussed work. *Review completed to add to existing recovery plans, will be reported to Q&P in October 2023*
- **% waiting less than 4-week (new standard)-** The final redesigned pathway for CYPS Neurodevelopmental has been clearly defined in draft and will be presented to the Community Oversight Group on 26th October 2023. Action plan delivery for North Cumbria Working age Adults have resulted in a recent improvement in performance. The new 4-week wait standard is monitored at the Community Oversight Group with data, risks and actions. *Recovery plans in place*
- **Live within our means -** Groups / Departments highlighted areas under review to impact on financial performance. BDG monthly finance meetings are in place to agree actions to impact on the Trust financial position and individual locality forecast positions in year.

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Sep 2023

	Ref	Indicator Name	Variation	Assurance	Performance	Standard	Plan	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Normal Variation	Consistently Fail	83.7%	95.0%	Internal	High (Action)	Decreased in the month	SR
	C02	Did we listen to you? (PoY)	Normal Variation	Consistently Fail	83.2%	95.0%	Internal	High (Action)	Decreased in the month	SR
	C03	Were staff kind and caring? (PoY)	Normal Variation	Achieve at Random	90.5%	95.0%	Internal	Med (Monitoring)	Decreased in the month	SR
	C04	Did you feel safe? (PoY)	Normal Variation	Achieve at Random	87.9%	95.0%	Internal	Med (Monitoring)	Decreased in the month	SR
	C05	Were you given helpful information? (PoY)	Normal Variation	Consistently Fail	83.6%	95.0%	Internal	High (Action)	Remaining stable	SR
People	P01	Turnover	Normal Variation	Achieve at Random	10.8%	10.0%	National	Med (Monitoring)	Remains stable across all localities	LS
	P02	Sickness in Month	Improvement	Consistently Fail	6.6%	5.0%	National	High (Action)	Improvement has stabilised below 24 month average	LS
	P03	% of Training Compliance (Courses with a Standard)	Improvement	Consistently Fail	34.6%	100.0%	Internal	High (Action)	9 out of 27 courses are achieving standard	LS
	P04	Appraisal rate	Improvement	Consistently Fail	76.3%	85.0%	Internal	High (Action)	Following strong improvement trend has dipped	LS
	P05	% Clinical Supervision completed	Improvement	Consistently Fail	54.9%	80.0%	Internal	High (Action)	Gradual improvement. Last 7 points above average	LS
	P06	People Pulse Health & Wellbeing satisfaction	SPC N/A	No Standard	65.7%	No Std	No Plan	Low (No Standard)	Risen from 60% in January 2023 to 65.7% in April 2023	LS
Quality Care	Q01	Restrictive intervention incidents	Concern	No Standard	27	No Std	No Plan	Med (Monitoring)	Significant increase in month due to specific patient	SR
	Q02	Serious Incidents	Normal Variation	No Standard	24	No Std	No Plan	High (Action)	Despite low numbers, action is required due to magnitude	RN
	Q03	Harm Incidents	Normal Variation	No Standard	1,741	No Std	No Plan	Low (No Standard)	Decreased in the month, reported within expected range	RN
	Q04	Safeguarding and Public Protection (SAPP)	Concern	No Standard	1,394	No Std	No Plan	Med (Monitoring)	Reported above the mean average for 9th consecutive month	RN
	Q05	Long term segregation and prolonged seclusion	Normal Variation	No Standard	21	No Std	No Plan	Low (No Standard)	11 out of last 12 months reported better than average	SR
	Q06	Aggression and Violence	Normal Variation	No Standard	1,419	No Std	No Plan	Med (Monitoring)	Steep rises and falls in numbers due to current inpatient profile	RN
	Q07	Number of Complaints	Normal Variation	No Standard	72	No Std	No Plan	Low (No Standard)	Increased in the month, remaining within expected range	RN
	Q08	Care Plans compliance	Improvement	Consistently Fail	94.4%	95.0%	Internal	Med (Monitoring)	Remaining stable in the month, close to standard	SR
	Q09	Risk Assessments compliance	Normal Variation	Achieve at Random	95.0%	95.0%	Internal	Low (On Track)	Met standard for the first time in 15 months	SR
	Q10	CPA Completed review	Normal Variation	Consistently Fail	86.8%	95.0%	Internal	High (Action)	Below target but huge step improvement this month	SR
	Q11	Staffing fill rates	Normal Variation	Achieve at Random	143.1%	120.0%	National	High (Action)	Reported above standard, night rates now included	SR
Person Led Care	A01	Out of Area Placement bed days	Normal Variation	Achieve at Random	249	135	LTP	High (Action)	Increased in month, related to 15 patients within adult pathway	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Normal Variation	Consistently Fail	93.8%	85.0%	National	High (Action)	Increase in month, above target, 3mths better than average	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	No Standard	21.7%	No Std	No Plan	Low (No Standard)	Increased in the month within expected range	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	No Standard	38.5%	No Std	No Plan	Low (No Standard)	Decreased in the month within expected range	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Consistently Fail	10.6%	7.5%	National	High (Action)	Increased in month below upper control limit	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	No Standard	39.4%	No Std	No Plan	Med (Monitoring)	13 out of 33, fluctuates due to low numbers	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Concern	No Standard	80.6%	No Std	No Plan	Med (Monitoring)	402 out of 499. Performance has dipped in last 6 months	RD
	A08	% PLT ED Referrals seen within 1 hour	Normal Variation	No Standard	63.4%	No Std	LTP	Med (Monitoring)	Significant increase in month	RD
	A09	% PLT Ward Referrals seen within 24 hours	Normal Variation	No Standard	84.1%	No Std	LTP	Low (No Standard)	Significant increase in month	RD
	A10	72 hour Follow-Up	Normal Variation	Consistently Achieve	93.8%	80.0%	LTP	Low (On Track)	Consistently exceeds 80% standard	RD
	A11	% Waiting 4 wks or less to treatment (WAAOP)	SPC N/A	No Standard	24.6%	No Std	No Plan	High (Action)	75.4% (3,499 of 4,642) have been waiting longer than 4 weeks	RD
	A12	% Waiting 4 wks or less to receive help (CYPS)	SPC N/A	No Standard	9.5%	No Std	No Plan	High (Action)	90.5% (4,452 of 4,920) have been waiting longer than 4 weeks	RD
	A13	% Waiting 4 wks or less to receive help (CYPS Neuro)	SPC N/A	No Standard	6.2%	No Std	No Plan	High (Action)	93.8% (4,030 of 4,295) have been waiting longer than 4 weeks	RD
	A14	CYPS Eating Disorders (urgent referrals)	Improvement	Achieve at Random	100.0%	95.0%	LTP	Low (On Track)	Consistently met the standard for 16 months	RD
	A15	CYPS Eating Disorders (routine referrals)	Normal Variation	Achieve at Random	93.3%	95.0%	LTP	Med (Monitoring)	Significant increase in the month, almost at standard	RD
	A16	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	70.0%	60.0%	LTP	Low (On Track)	Consistently exceeds 60%, although dropped 11.5% this month	RD
	A17	Talking Therapies % Moving to Recovery (IAPT)	Normal Variation	Achieve at Random	50.8%	50.0%	LTP	Low (On Track)	Slight decrease in month but remains above standard	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC N/A	SPC N/A	-5.3M	-5.3M	No Plan	High (Action)	23/24 forecast under significant pressure	KS
	S02	Capital spend compared to plan (£)	SPC N/A	SPC N/A	-1.2M	1.2M	No Plan	Low (On Track)	Capital programme overcommitted	KS
	S03	Cash balance compared to plan (£)	SPC N/A	SPC N/A	34.2M	20.7M	No Plan	Low (On Track)	Cash balance on plan due to additional monies	KS

Commitments to our Carers & Patients - Headline Commentary

Reporting Period: Sep 2023

Headline Challenges

Friends and Family Test Question

- **How was your experience? (FFT)** - At 83.7% this is not meeting standard and has decreased in the month. The latest national published FFT score for England is reported at 87% (August 23).

Points of You Questions

- **Did we listen to you?** - At 83.2% this remains below standard and has decreased in the month. This is the lowest performing question this month. 12 of 21 people not feeling listened to are relating to CYPS and Adult Community Mental Health teams.
- **Were staff kind and caring?** – At 90.5% this represents the lowest score for 5 months but remains within expected variation levels. Low satisfaction scores for North Cumbria services have impacted scores for the Trust.
- **Did you feel safe?** - At 87.9% this remains below standard. People not feeling safe are from a variety of community and inpatient services and not from one particular area.
- **Were you given helpful information?** - At 83.6% this continues to be a low scoring question. 15 of 33 people not feeling they had useful information are relating to CYPS and Adult Community Mental Health teams.

Key focus areas of concern

- **How was your experience? (FFT)**
- **Did we listen to you? (PoY)**
- **Did you feel safe? (PoY)**
- **Were you given helpful information? (PoY)**

Positive Assurance / Improvement

Efforts continue to increase and respond to feedback within the Trust to support the improvement of services. September had the highest number of You Said – We Did posters completed by teams.

Although there was a reduction in feedback levels during September, quarter 2 saw the highest recorded levels of feedback for over 3 years.

More people are using the online form to submit feedback
Review of the PoY survey has taken place. Working on developing a new version of the feedback form

Mitigations/actions

How was your experience? (FFT)

- This is discussed at the Service User and Carer Reference Group and Locality Involvement and Experience Groups.
- Review of current internal reporting against national methodology.

Did we listen to you? (PoY)

- The Trust Level Service User and Carer Reference Group is being utilised more effectively to engage with, inform and listen to service users and carers. A recent example would be in relation to sharing views on the Oxevision system.

Did you feel safe? (PoY)

- The new version of the Trust survey will explain what we mean by 'safe' to support people to give a measured/meaningful response that can be interpreted by wards/teams when people report feeling less safe.
- A detailed report is being developed to support North Cumbria services to be responsive to people feeling less safe than in other localities.

Were you given helpful information? (PoY)

- Carers Together Group is reviewing all carer information to ensure it is up to date and relevant, approved updated and co-designed resource has been made available to all services.

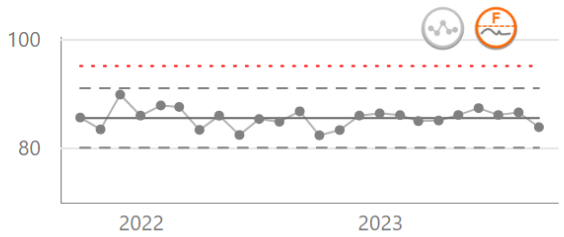
Commitments to our Carers & Patients

Reporting Period: Sep 2023

How was your experience? (FFT)

High (Action)

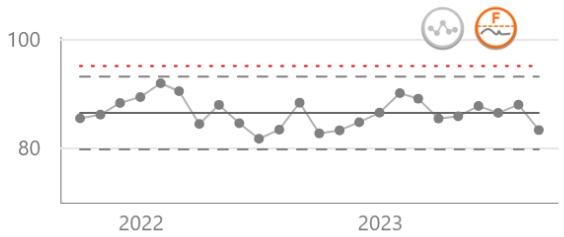
Ref - C01 Performance - 83.7% Standard - 95.0%



Did we listen to you? (PoY)

High (Action)

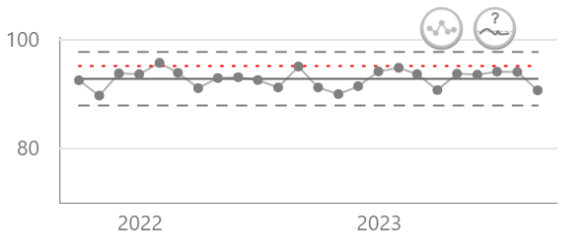
Ref - C02 Performance - 83.2% Standard - 95.0%



Were staff kind and caring? (PoY)

Med (Monitoring)

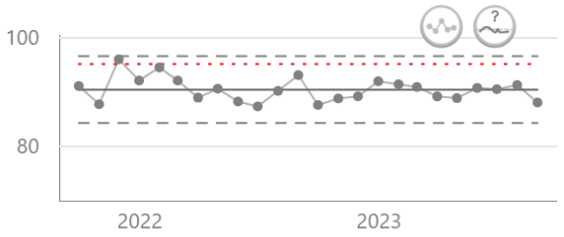
Ref - C03 Performance - 90.5% Standard - 95.0%



Did you feel safe? (PoY)

Med (Monitoring)

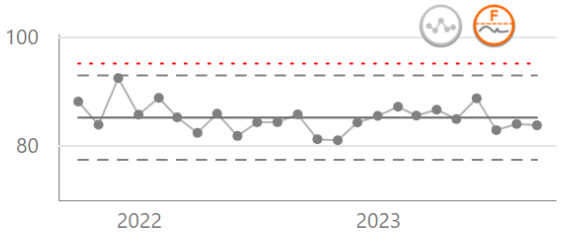
Ref - C04 Performance - 87.9% Standard - 95.0%



Were you given helpful information? (PoY)

High (Action)

Ref - C05 Performance - 83.6% Standard - 95.0%



Great Place to Work - Headline Commentary

Reporting Period: Sep 2023

Headline Challenges

- **Sickness** – The confirmed sickness within the report relates to August and is reported at 6.6%. There has been an increase in Covid related absence in the month. The provisional sickness for September 2023 is 6.21%.
- **% of Training Compliance (Courses with a standard)** – In September, 9 out of 27 courses are achieving or above the required standard, 18 remain below standard. Key challenges are linked to clinical demand to release staff to undertake essential training and appraisal.
- **Clinical Supervision** – Performance still under compliance standard, however positive improvement seen from last month's report.
- **Appraisals** – Performance decreased in the month and remains below standard despite a longer-term improvement in performance

Key focus areas of concern

- **Sickness**
- **% of Training Compliance (Courses with a standard)**
- **Clinical Supervision**

Positive Assurance / Improvement

- **Clinical Supervision** - improved from 48.7% to 54.9% this month
- **% of Training Compliance (Courses with a standard) -** Continuous proactive engagement with services around priority training including Information Governance, Fire and Safeguarding training.
- Launch of See Me First initiative

Mitigations/actions

Sickness

- Dedicated Wellness Support Officers to support robust management of Short-Term Sickness reviews, to keep staff well at work
- Continued support in management of Long-Term Sickness to support signposting and recovery plans
- Promotion of wellbeing conversations to support local stress risk assessments, carers passports and Wellness Recovery Action plans (WRAP), with dedicated locality resource.
- Promotion of the vaccine clinics for flu and COVID-19

% of Training Compliance (Courses with a standard)

- A further update has been made to the training competencies to ensure that all staff are assigned to the correct safeguarding courses.
- All localities are reviewing the Training Needs Assessment and providing feedback on relevance of courses against staff position.
- Localities continue to work through Training Trajectory plans with CBU's. This will now incorporate the new compliance standards set against all mandated training.

Clinical Supervision

- Directive for Clinical Supervision to be a priority focus as a CQC must do.
- This is being monitored through local CMT and Quality Standards & Oversight meetings within CBU's, setting expectations with CBU leadership team to re-embed supervision.
- Establishing and removing barriers to recording and solutions to data issues, working with the CNTW Training Academy

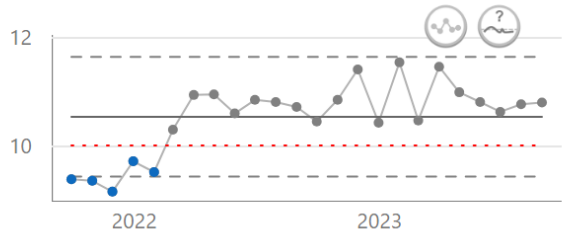
Great Place to Work

Reporting Period: Sep 2023

Turnover

Med (Monitoring)

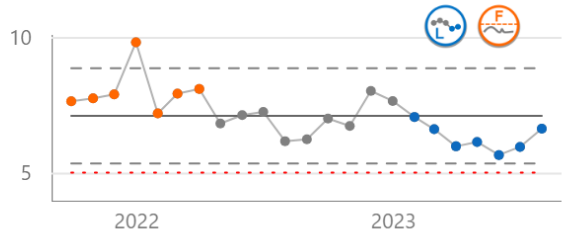
Ref - P01 Performance - 10.8% Standard - 10.0%



Sickness in Month

High (Action)

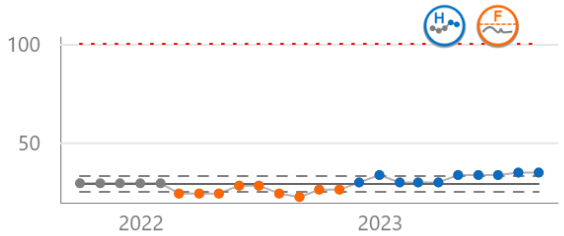
Ref - P02 Performance - 6.6% Standard - 5.0%



% of Training Compliance (Courses with a Standard)

High (Action)

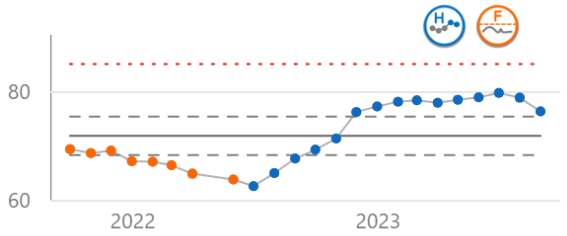
Ref - P03 Performance - 34.6% Standard - 100....



Appraisal rate

High (Action)

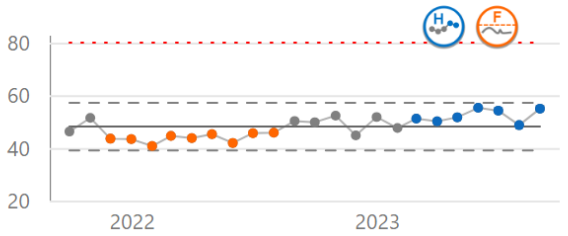
Ref - P04 Performance - 76.3% Standard - 85.0%



% Clinical Supervision completed

High (Action)

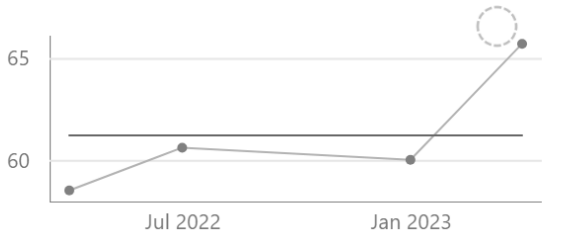
Ref - P05 Performance - 54.9% Standard - 80.0%



People Pulse Health & Wellbeing satisfaction

Low (No Standard)

Ref - P06 Performance - 65.7% Standard - No Std



Quality Care, Everyday - Headline Commentary

Reporting Period: Sep 2023

Headline Challenges

- **Restrictive Intervention Incidents** – Increased within North locality, 50% relate to restrictions required to support safe management of a specific individual patient.
- **Serious Incidents** – The number of Serious Incidents has increased this month but is still within expected variation. There has not been any significant variance over last 2 years
- **Safeguarding and Public Protection** – The number of reported safeguarding incidents has decreased for the third consecutive month.
- **Staffing Fill Rates -** Reporting this month is now via a manual collection for all areas with the exception of North Cumbria and Lotus ward which are using allocate system for bank and agency and substantive rostered staff. Performance has dropped significantly with fill rate being highest in 24 months.
- **CPA Complete Review** – Large uptick in Performance with an increase to 86.8%, the target is 95%. This bucks a long term decline in performance
- **Care Plan Compliance** – Current performance is 94.4%, the target is 95%. There was a small decrease during the month, almost at standard.

Key focus areas of concern

- **Serious Incidents**
- **Safeguarding and Public Protection**
- **Staffing Fill Rates**
- **CPA Completed Review**

Positive Assurance / Improvement

Aggression and Violence - Activity has been reported at the lowest level within this financial year, against a backdrop of overall incident increase for the month of September.

Long term segregation and seclusion - Positive outcomes for service user who has recently come out of LTS

Risk Assessment – Met standard for the first time in 15 months

CPA Completed Reviews –7% increase in performance which is the largest improvement across the 2 years

Mitigations/actions

Serious Incidents - Each serious incident is subject to an investigation which identifies areas of learning and recommendations. This forms an action plan and is subject to Trust and ICB governance processes to ensure that learning is embedded.

Safeguarding and Public Protection

- Increased safeguarding reporting generally is in line with national trends and linked to greater awareness because of the rollout of level 3 training. Sapp Triage have highlighted that not all safeguarding incident reports are categorised correctly, and better data is required to enable analysis of safeguarding reporting.
- An amendment to the data recording of outcome options via SAPP triage is to being trialled to better understand potential issues

Staffing Fill Rates – Inpatient Staffing – Enhanced MDT Model work is progressing as part of the Urgent Care Programme Board. The outcome will produce a revised skill mix model for Adult Acute wards. Timeframe for completion end of Q3

CPA Completed Review

- Some improvement notes in care plan compliance and CPA metrics. Services are focusing pieces of work around case load management, and weekly overview of metric with support of administrative staff to support clinicians to identify capacity to complete.
- Dedicated focus within Commissioning and Quality Assurance Data Quality staff to review RiO and update records accordingly if reviews have been completed.

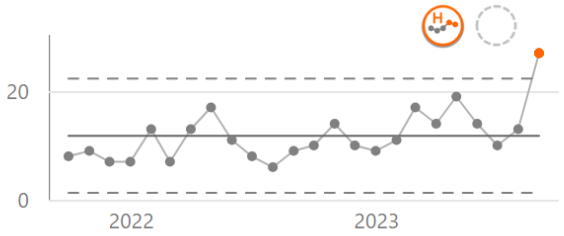
Quality Care, Everyday

Reporting Period: Sep 2023

Restrictive intervention incidents

Med (Monitoring)

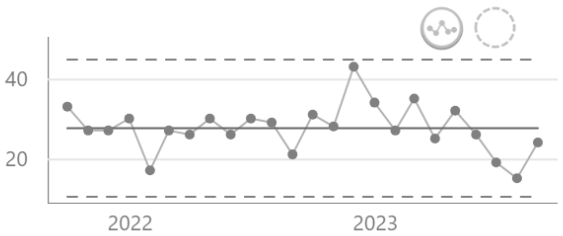
Ref - Q01 Performance - 27 Standard - No Std



Serious Incidents

High (Action)

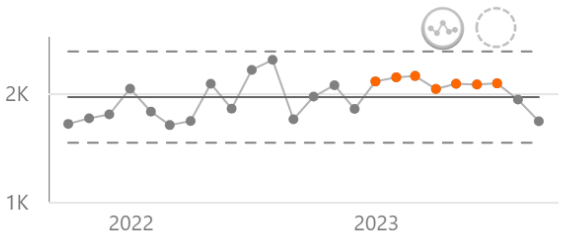
Ref - Q02 Performance - 24 Standard - No Std



Harm Incidents

Low (No Standard)

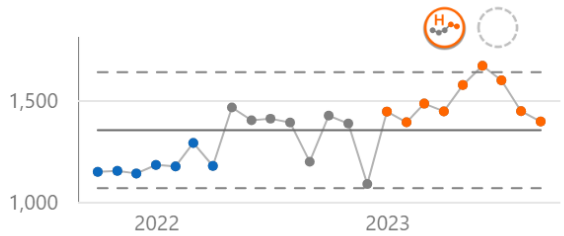
Ref - Q03 Performance - 1,741 Standard - No Std



Safeguarding and Public Protection (SAPP)

Med (Monitoring)

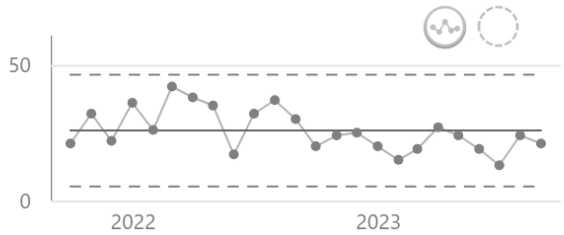
Ref - Q04 Performance - 1,394 Standard - No Std



Long term segregation and prolonged seclusion

Low (No Standard)

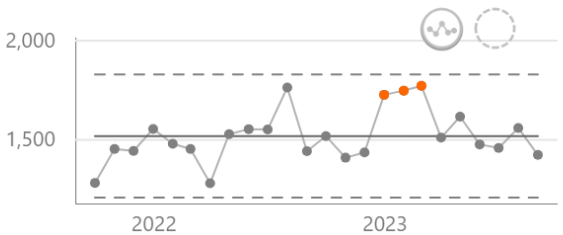
Ref - Q05 Performance - 21 Standard - No Std



Aggression and Violence

Med (Monitoring)

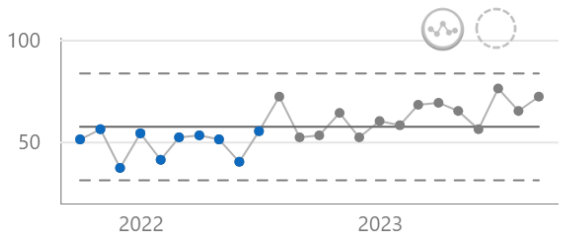
Ref - Q06 Performance - 1,419 Standard - No Std



Number of Complaints

Low (No Standard)

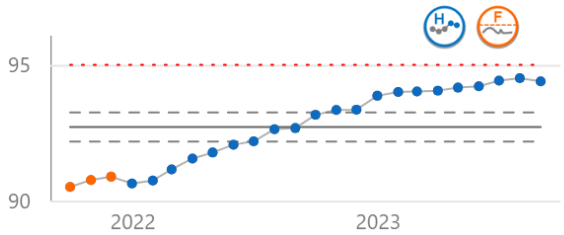
Ref - Q07 Performance - 72 Standard - No Std



Care Plans compliance

Med (Monitoring)

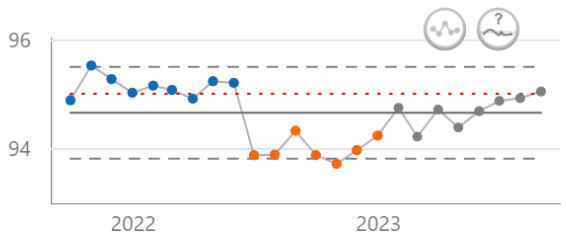
Ref - Q08 Performance - 94.4% Standard - 95.0%



Risk Assessments compliance

Low (On Track)

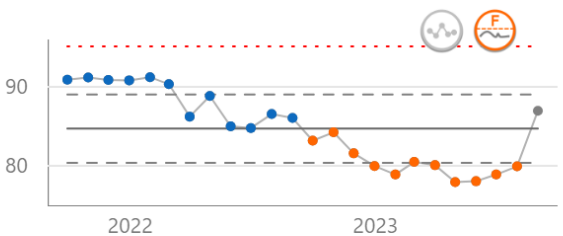
Ref - Q09 Performance - 95.0% Standard - 95.0%



CPA Completed review

High (Action)

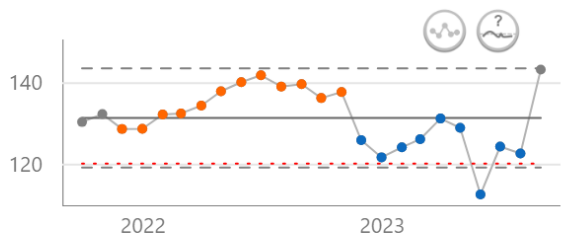
Ref - Q10 Performance - 86.8% Standard - 95.0%



Staffing fill rates

High (Action)

Ref - Q11 Performance - 143.1% Standard - 120.0%



Person Led Care, when and where it's needed - Headline Commentary

Headline Challenges

- **Out of Area Placements/Clinically Ready for Discharge/ Bed Occupancy -** All remain reported off track
- **Crisis Very Urgent Referrals seen within 4 hours –** At 39.4%, very low referral numbers means performance fluctuates significantly.
- **Psychiatric Liaison Referrals in ED within 1 hour –** Significant improvement in the month but lower than peers. The challenges remain in North.
- **New 4-week standard waiting times targets are reported in this month's report, this has been introduced since July 23.**
    - **% waiting < 4 weeks to Treatment Adult and Older Adult Waits to Treatment** – 24.6% of referrals have been waiting 4 weeks or less to treatment.
    - **% waiting < 4 weeks to Receive Help - All CYPS** – 9.5% of referrals have been waiting 4 weeks or less to receive help.
    - **% waiting < 4 weeks to Receive Help - CYPS Neuro Developmental** – 6.2% of referrals have been waiting have 4 weeks or less to receive help.

Key focus areas of concern

- **Crisis Very Urgent Referrals seen within 4 hours**
- **Psychiatric Liaison Referrals in ED within 1 hour**
- **% Waiting < 4 weeks to Treatment –**
    - **Adult and Older Adult waits**
- **% Waiting < 4 weeks to Receive Help –**
    - **All CYPS**
    - **CYPS Neuro Developmental waits**

Positive Assurance / Improvement

- **EIP (Early Intervention Psychosis) -** consistently above standard.
- **72 hour follow up -** remains consistently above the standard
- **CYPS Eating Disorders (Urgent)-** on target this month
- **Eating Disorder Routine** – significant improvement in the month, the highest reported % in 24 months
- **Out of Area Placements –** As at 16-10-23 there are no inappropriate Out of Area Placements.
- **Psychiatric Liaison Referrals in ED 1 hour and 24hr on wards**– Both showing significant improvement in month

Mitigations/actions

- **Crisis Very Urgent Referrals seen within 4 hours -** Locality recovery actions are being reviewed alongside the data at the Access Oversight Group. There is also a working group to review the effectiveness of the implementation of the new standards for Crisis including, improving the processes and recording. A new Crisis Model is being developed as part of the Urgent Care and Inpatient Programme. This will involve, improving the 136 suite flow, developing alternatives to admission, community interface, discharge model/in-reach and the development of 111 for Mental Health. *Recovery plans in place*
- **Psychiatric Liaison Referrals in ED within 1 hour -** Urgent and Emergency sub-group of the Access and Oversight group has been reinstated to focus on improvement. Also, Trust Innovation Group supported by a Clinical Lead have reviewed practices and supported improvement across all Localities. There have been a large uptick in performance of 7.4% to 63.4% this month because of this focussed work. *Review completed to add to existing recovery plans, will be presented to Q&P Oct 2023*
- **% waiting less than 4-week (new standard)-** The final redesigned pathway for CYPS Neurodevelopmental has been clearly defined in draft and will be presented to the Community Oversight Group on 26th October 2023. Action plan delivery for North Cumbria Working age Adults have resulted in a recent improvement in performance. The new 4-week wait standard is monitored at the Community Oversight Group with data, risks and actions. *Recovery plans in place*

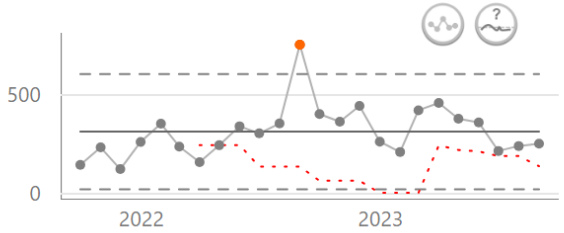
Person Led Care, when and where it's needed

Reporting Period: Sep 2023

Out of Area Placement bed days

High (Action)

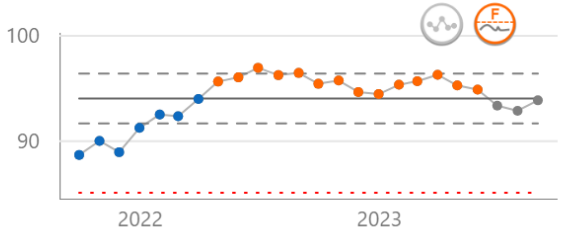
Ref - A01 Performance - 249 Standard - 135



Bed Occupancy including leave (open beds on RiO)

High (Action)

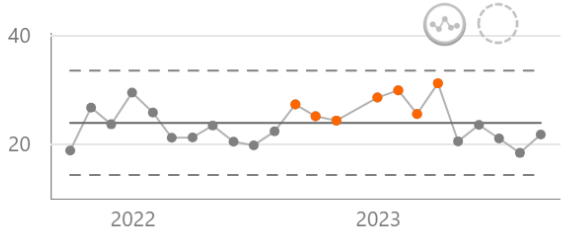
Ref - A02 Performance - 93.8% Standard - 85.0%



% Adult inpatients discharged with LOS > 60 days

Low (No Standard)

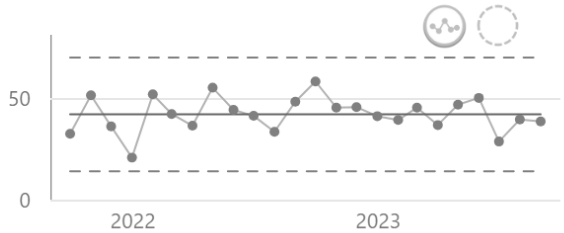
Ref - A03 Performance - 21.7% Standard - No Std



% OP inpatients discharged with LOS > 90 days

Low (No Standard)

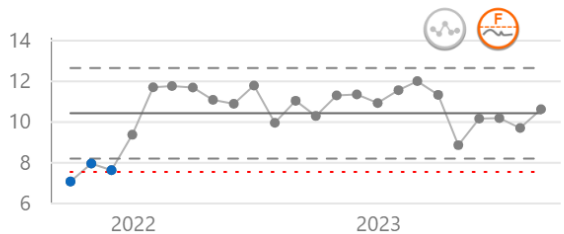
Ref - A04 Performance - 38.5% Standard - No Std



Clinically Ready for Discharge (formerly DTOC)

High (Action)

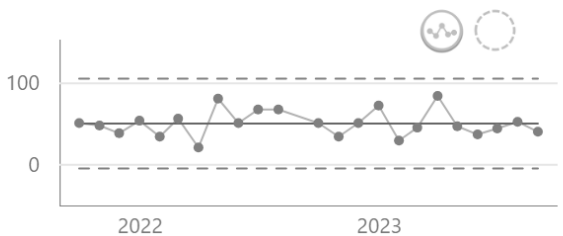
Ref - A05 Performance - 10.6% Standard - 7.5%



Crisis % Very urgent seen within 4 hours (WAA&OP)

Med (Monitoring)

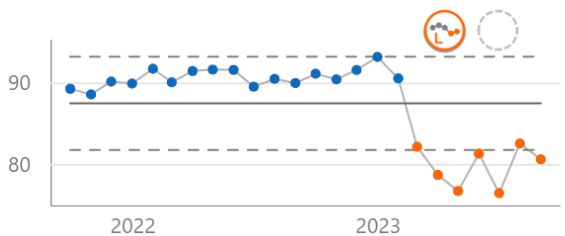
Ref - A06 Performance - 39.4% Standard - No Std



Crisis % Urgent seen within 24 hours (WAA&OP)

Med (Monitoring)

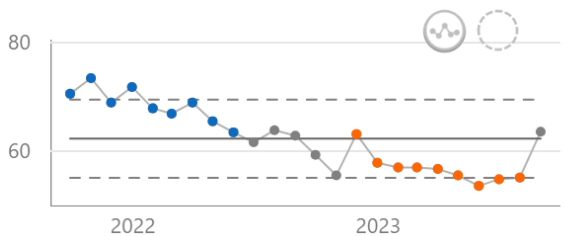
Ref - A07 Performance - 80.6% Standard - No Std



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

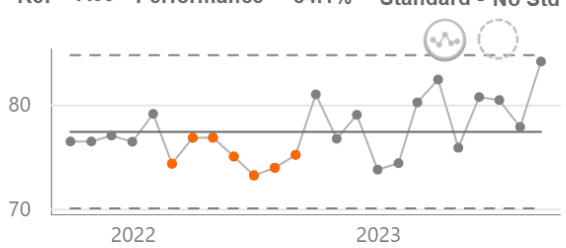
Ref - A08 Performance - 63.4% Standard - No Std



% PLT Ward Referrals seen within 24 hours

Low (No Standard)

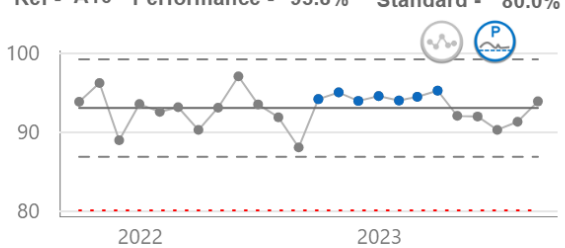
Ref - A09 Performance - 84.1% Standard - No Std



72 hour Follow-Up

Low (On Track)

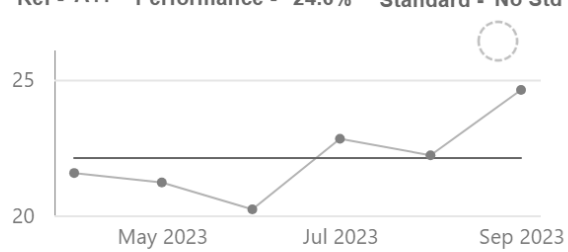
Ref - A10 Performance - 93.8% Standard - 80.0%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

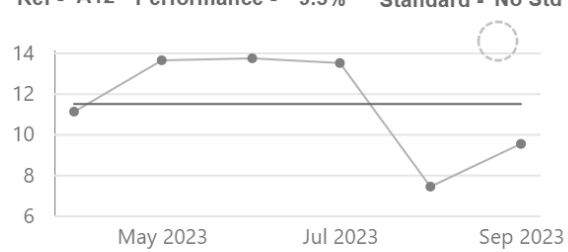
Ref - A11 Performance - 24.6% Standard - No Std



% Waiting 4 wks or less to receive help (CYPS)

High (Action)

Ref - A12 Performance - 9.5% Standard - No Std



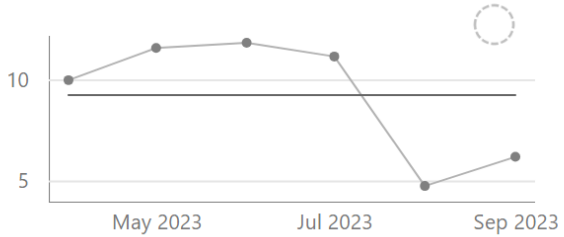
Person Led Care, when and where it's needed

Reporting Period: Sep 2023

% Waiting 4 wks or less to receive help (CYPS Neuro)

High (Action)

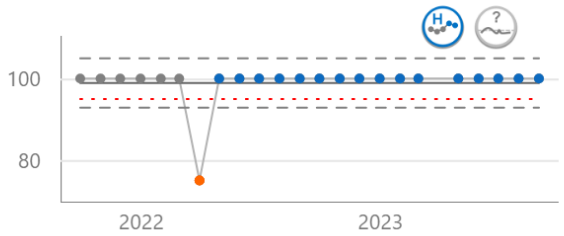
Ref - A13 Performance - 6.2% Standard - No Std



CYPS Eating Disorders (urgent referrals)

Low (On Track)

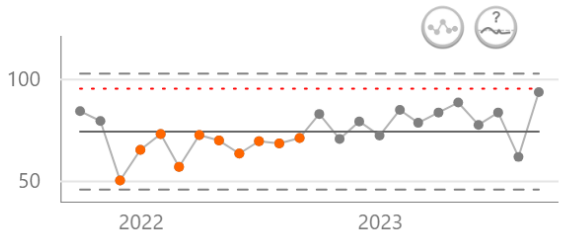
Ref - A14 Performance - 100.0% Standard - 95.0%



CYPS Eating Disorders (routine referrals)

Med (Monitoring)

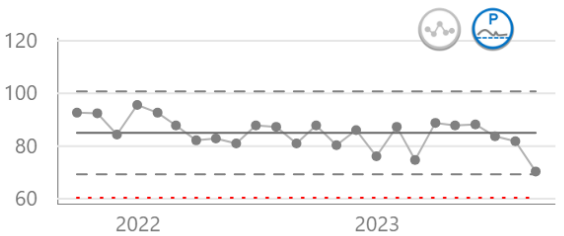
Ref - A15 Performance - 93.3% Standard - 95.0%



EIP – starting treatment in 14 days

Low (On Track)

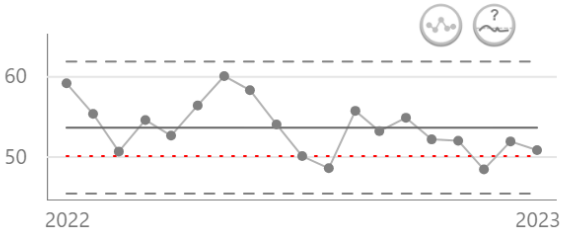
Ref - A16 Performance - 70.0% Standard - 60.0%



Talking Therapies % Moving to Recovery (IAPT)

Low (On Track)

Ref - A17 Performance - 50.8% Standard - 50.0%



Sustainable for the Long Term - Headline Commentary

Headline Challenges

- The Trust is reporting a £5.6m deficit at month 6 which is marginally better than plan. The Trust required efficiencies are phased into the second half of the year to as part of the Trust plan to deliver financial break-even. The position at month 6 includes a £5.8m gain on disposal following the agreement of the sale of land at Northgate.
- At the end of month 6 the Trust has spent £9.0m on agency staff against a plan £8.4m and against the Trust's nationally applied agency ceiling of £7.2m.
- The Trust is forecasting to deliver the plan of financial break-even at the end of the year. The major risk to delivery of financial plan is WTE numbers, which remain over planed levels.
- Cost trends need to change to deliver the financial forecast.
- There is significant pressure on several inpatient wards to deliver services within the revised baseline staffing establishments, all four inpatient CBUs are overspent.
- The Trust financial plan includes gains on disposal of land. The Trust forecast includes gains on disposal of 2 land sales. At month 6 the gain on disposal of the land sale at Northgate has been agreed and included. The sale of land at St Georges remains forecast to be delivered this year and is included in the Trust forecast.

Key focus areas of concern

- Year to date the Trust is overspent across key budgets
- Delivery of the Trust planned efficiencies is a risk to delivery of the Trusts planned financial break-even
- The level of WTE across the Trust (particularly temporary staffing)
- Trust cash balances have reduced at month 6 and will continue to come under pressure from continued monthly deficits. The Trust plan reflects surpluses in second half of the year. If the surpluses are not delivered cash will be further depleted.
- A revised capital programme has been proposed and approved within the Trust.
- Trust underlying financial position - planning 24/25

Positive Assurance / Improvement

- Trust current cash balances are over plan from slippage in capital programme and PDC secured at the end of 22/23
- Senior Management commitment to improve financial position – focus of BDG on a monthly basis with specific financial reviews of areas of most concern
- Monthly agency spend at month 6 is the lowest this financial year at £1.29m which is on a continued downward trend. The Trust is forecasting this to reduce to £1.1m a month by Q4.

Mitigations/actions

- BDG monthly finance focus sessions to agree actions to impact on the Trust financial position and review of progress to deliver the Trust Cost Improvement Plan.
- Groups / Departments highlighted areas under review to impact on financial performance. BDG discussions to clarify where they improve financial forecast.
- Daily staffing reviews taking place across inpatient areas.
- Agreement of financial trajectories to deliver financial break-even.
- Pursing capital funding for CEDAR scheme to support Trust cash balances.

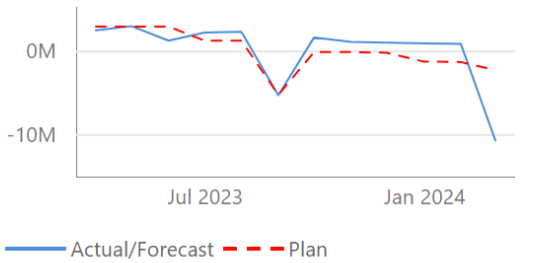
Sustainable for the Long Term

Reporting Period: Sep 2023

Live within our means (I&E Surplus/Deficit £)

High (Action)

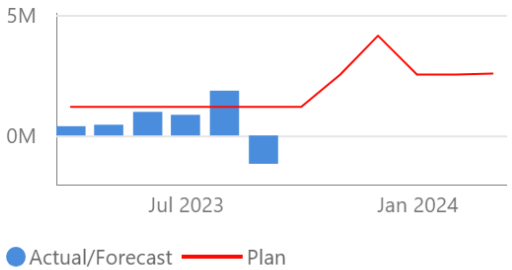
Ref - S01 Actual/Forecast - -5.3M Plan - -5.31M



Capital spend compared to plan (£)

Low (On Track)

Ref - S02 Actual/Forecast - -1.2M Plan - 1.18M



Cash balance compared to plan (£)

Low (On Track)

Ref - S03 Actual/Forecast - 34.2M Plan - 20.7M

C01 - How was your experience? (FFT)

Risk Rating - **High (Action)**

Overall how was your experience with our service? (FFT)

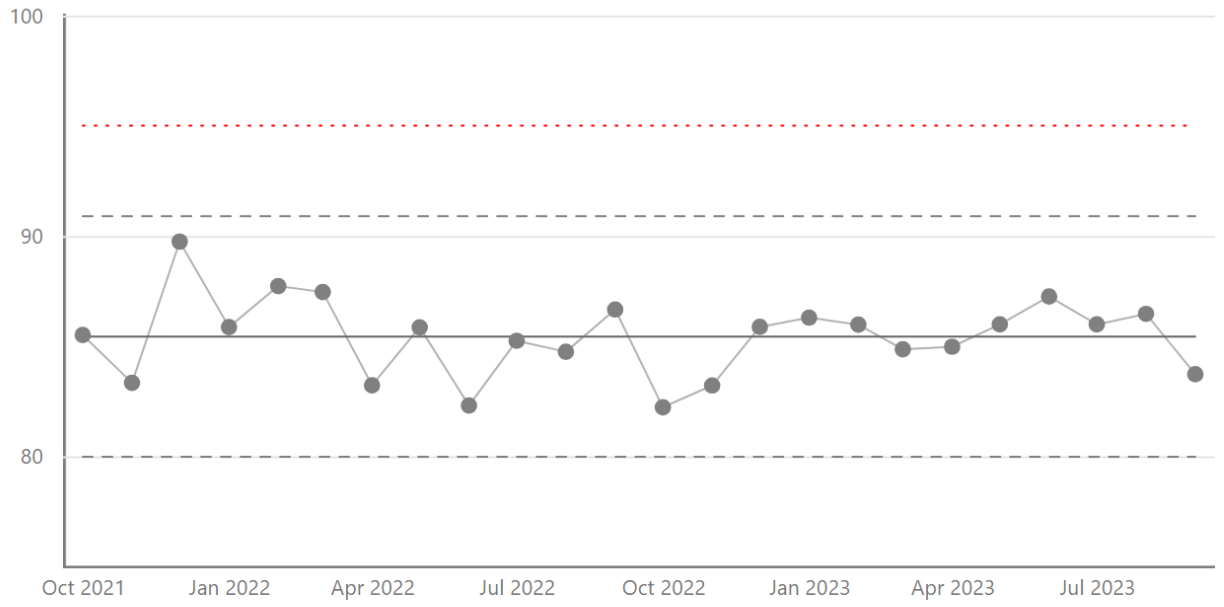
Performance - 83.7%

Standard - 95.0%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	85.8%	95.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	67.3%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	84.1%	95.0%	Improvement	Achieve at Random
South Locality Care Group	90.7%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 83.7% for September was within the expected range of 80% to 91% which remains below the standard of 95%. If we continue to do what we are doing then we will never meet the standard of 95%

Root Cause of the performance issue

A small percentage of service users and carers choose to share their experience through Points of You, the majority of whom provide positive comments on their experience. The main negative themes coming through are consistently communications with/from staff, being listened to and the availability of information.

Improvement Actions

Raising awareness of the feedback options and how they are accessed through the Points of You dashboard continues with engagement. A new version of the service user and carer experience survey is being developed. It is hoped that engaging to develop a survey with questions people want to answer could increase completion of surveys going forward.

Specialist involvement and carer roles inform service users and carers on how to share their views with the Trust. The Trust Level Service User and Carer Reference Group and Locality Level service user and carer forums provide face to face communication platforms for staff to inform, listen and provide information, they are also an opportunity for encouraging people to share their views.

Review and understand the communication issues raised and address the issues to improve feedback.

Review of current internal reporting against national methodology.

Raise awareness of the feedback dashboard. A usage audit has shown that use of the dashboard needs to be improved

Expected impact and by when

Improvement towards the standard and increased feedback received during 2023-24.

C02 - Did we listen to you? (PoY)

Did we listen to you when making decisions about care & treatment? (PoY)

Risk Rating - **High (Action)**

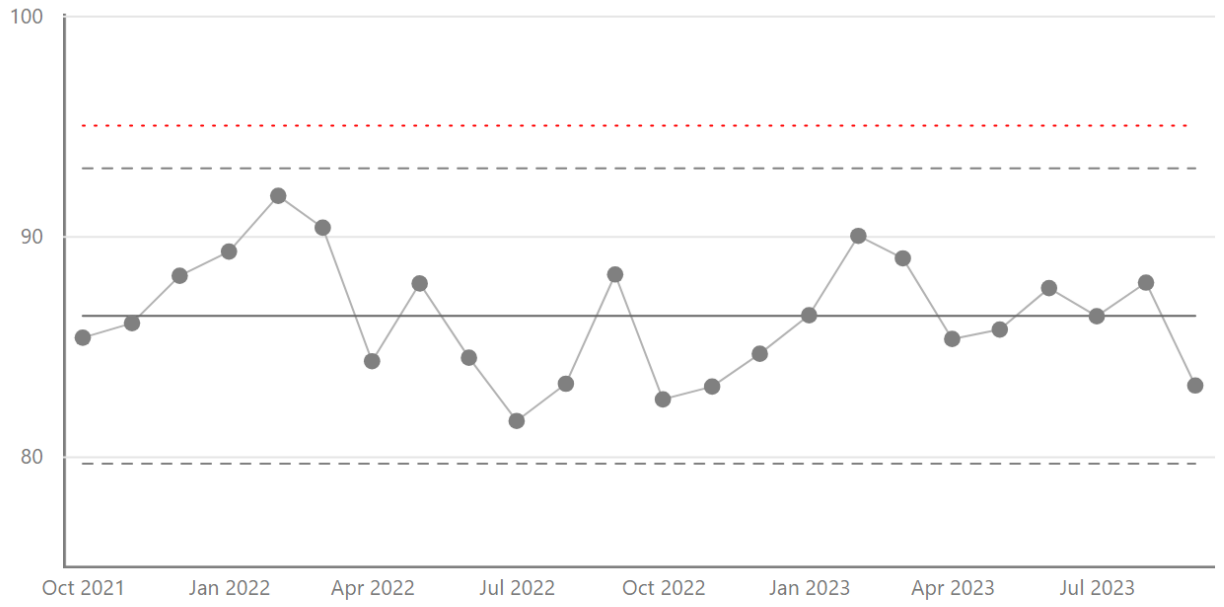
Performance - 83.2%

Standard - 95.0%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	84.0%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	60.3%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	91.8%	95.0%	Improvement	Achieve at Random
South Locality Care Group	88.2%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 83.2% for September was within the expected range of 80% to 93% which remains below the standard of 95%.

Root Cause of the performance issue

- North Cumbria Locality involvement activities have been falling, at a time when poorer experiences of services are being reported.
- Communication between staff & service users has overtaken being listened to as the most common negative theme within the communications theme.

Improvement Actions

- Localities that have scores below Trust average have been made aware, as well as being supported in how to effectively explore the themes associated.
- Teams should explore what service users and carers are telling them around the being listened to themed comments, with the aim of doing more of what people like and less of what is leading to a negative experience.
- North Cumbria locality have recognised the shift in outcomes and is looking at the root cause as wells as investigating new ways of patient and carer engagement to improve inclusivity and increase the number of returns from a broader range of patients.

Expected impact and by when

Improvement towards the standard and increased feedback received during 2023-24.

C03 - Were staff kind and caring? (PoY)

Were staff kind and caring? (PoY)

Risk Rating - **Med (Monitoring)**

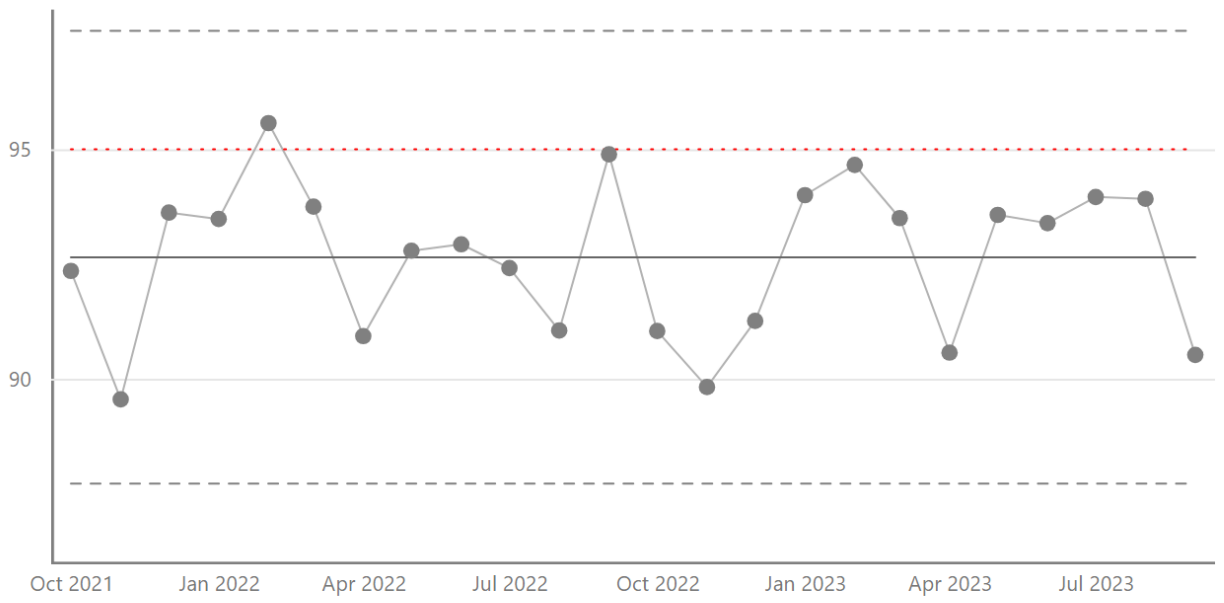
Performance - 90.5%

Standard - 95.0%

Achieve at Random
The standard for this indicator is within the upper and lower control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	90.2%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	75.4%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	95.0%	95.0%	Improvement	Achieve at Random
South Locality Care Group	95.3%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 90.5% for September was within the expected range of 88% to 98%. The standard of 95% falls within the expected range suggesting that we will sometimes meet the standard, but not consistently.

Root Cause of the performance issue

- The feedback received continues to be positive, however when the response is 'sometimes' there is no or limited narrative with the response to identified a common cause. People saying 'no' remain very rare occurrences.

Improvement Actions

- This feedback from carers and patients should be shared across the Trust to support staff wellbeing and resilience, including teams developing their monthly You Said – We Did posters.
- Responses to this question are overwhelmingly positive. Efforts should be made to make staff aware of this, to support resilience and satisfaction. A particular focus on sharing compliments could be supportive.

Expected impact and by when

- Ongoing through 2023-24

C04 - Did you feel safe? (PoY)

Did you feel safe with our service? (PoY)

Risk Rating - **Med (Monitoring)**

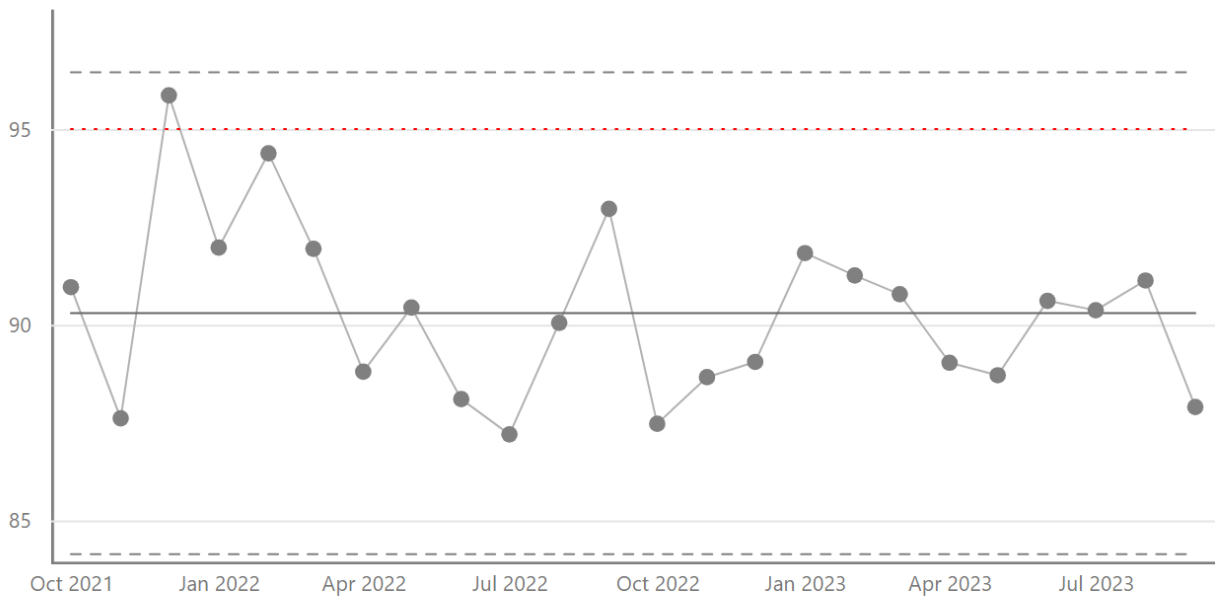
Performance - 87.9%

Standard - 95.0%

Achieve at Random
The standard for this indicator is within the upper and lower control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	89.3%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	74.2%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	88.1%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	94.6%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 87.9% for September was within the expected range of 84% to 96%. The standard of 95% falls within the expected range suggesting that we will sometimes meet the standard, but not consistently.

Root Cause of the performance issue

- 22 people reported not feeling safe during September.
- 356 people reported feeling safe.
- The majority of people reporting not feeling safe had accessed Community Treatments Teams (CYPS/Adult) making up 11 of these experiences.

Improvement Actions

- Teams should be accessing their feedback dashboard regularly to identify and respond to what prevents people from feeling safe.
- The new version of the experience survey (currently being developed) will explain what the Trust means by safe to support service users and carers to explore this in a meaningful and useful way in the future.

Expected impact and by when

- Ongoing through 2023-24

C05 - Were you given helpful information? (PoY)

Were you given information that was helpful? (PoY)

Risk Rating - **High (Action)**

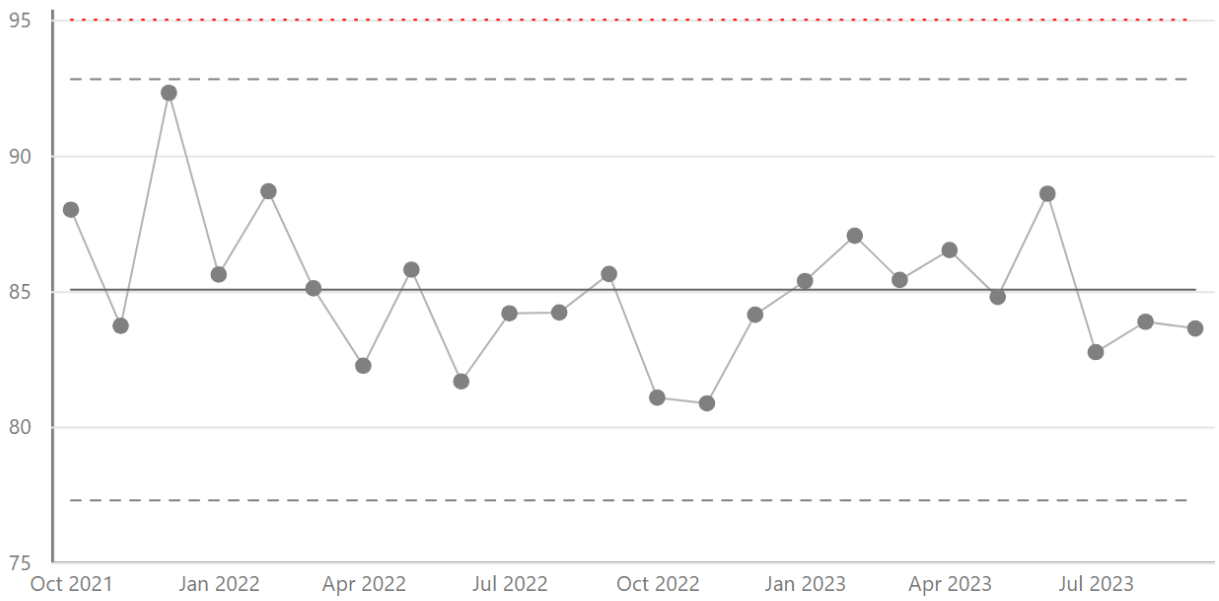
Performance - 83.6%

Standard - 95.0%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	85.0%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	62.7%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	85.3%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	92.4%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 83.6% for September was within the expected range of 77% to 93% which remains below the standard of 95%.

Root Cause of the performance issue

- The most common negative experiences were people being told they would receive information and it not arriving or people not receiving useful information in a way that suited their needs.

Improvement Actions

- Staff to be made aware of the health literacy toolkit available on the intranet. This has guidance and easy to use tools to support people to discuss literacy needs with service users and carers.
- Carers Together Group is reviewing all carer information to ensure it is up to date and relevant, approved updated and co-designed resource has been made available to all services.

Expected impact and by when

- Throughout 2023-24

P01 - Turnover

Turnover FTE 12 month rolling

Risk Rating - Med (Monitoring)

Performance - 10.8%

Standard - 10.0%

Achieve at Random

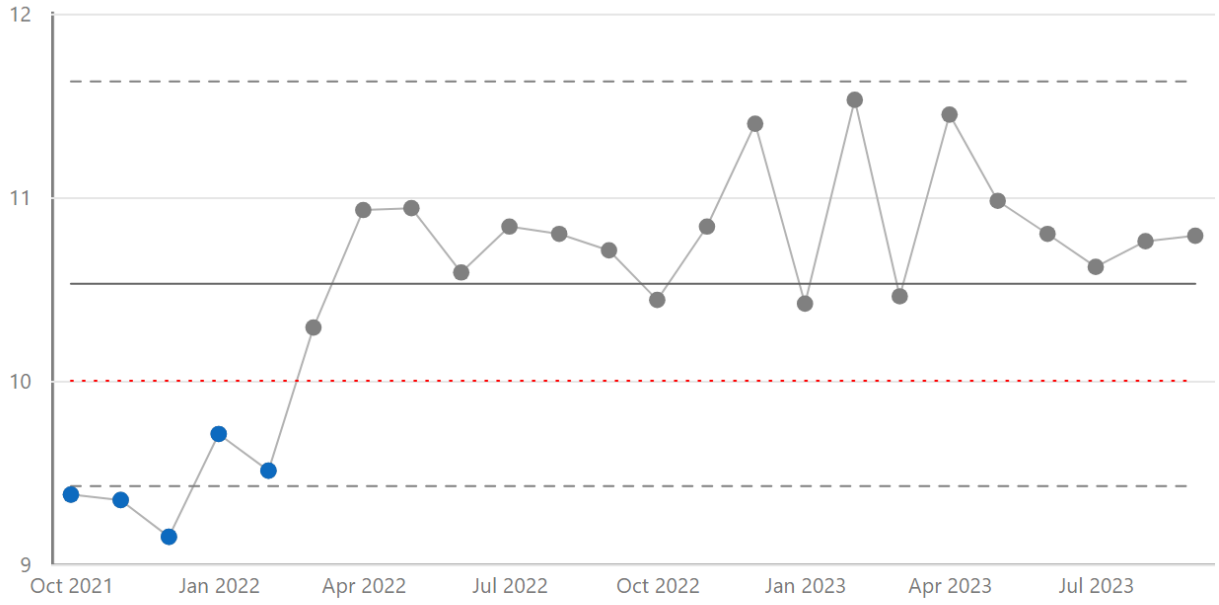
The standard for this indicator is within the upper and lower control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	10.3%	10.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	11.8%	10.0%	Normal Variation	Achieve at Random
North Locality Care Group	8.9%	10.0%	Improvement	Achieve at Random
South Locality Care Group	9.1%	10.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Turnover remained at 10.8% in September and was within the expected range of 9.4% and 11.6%.

Root Cause of the performance issue

- Recruitment and Retention.
- Staff health and wellbeing.

Improvement Actions

- Work undertaken to align vacancies with establishment information
- Introduction of vacancy control processes across all localities
- Retire and return requests reviewed and promoted to support retention
- Flexible working and reasonable adjustment review
- Emailing staff on Leavers report, inviting them to engage in an exit interview/questionnaire
- Emailing managers on New Starter report, ensuing staff onboarded, support through robust probationary period and local induction
- Reintroduction of face-to-face Corporate Induction from September 2023
- Promotion of annual Staff Survey and Quarterly People Pulse Survey
- Review of local induction requirements (safe day 1)
- Launch of See Me First initiative.

Expected impact and by when

- Aim to fill vacancies within 4-6 weeks
- Positive onboarding and improved training trajectories from Day 1
- Increase response to exit questionnaire and survey response, gathering robust data to inform action

P02 - Sickness in Month

Percentage of in month sickness absence

Risk Rating - **High (Action)**

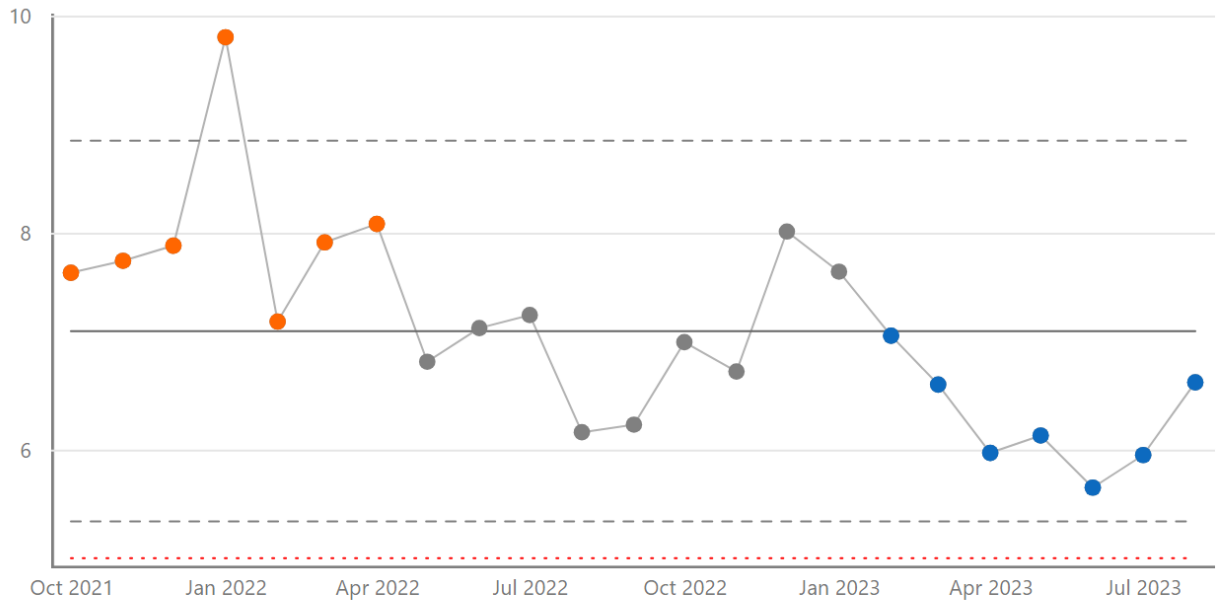
Performance - 6.6%

Standard - 5.0%

Consistently Fail
The standard for this indicator is outside the control limits

Improvement
This indicator is decreasing which shows improvement

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6.8%	5.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	7.2%	5.0%	Improvement	Consistently Fail
North Locality Care Group	6.5%	5.0%	Normal Variation	Consistently Fail
South Locality Care Group	7.5%	5.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

The chart shows the confirmed sickness for August 2023 and is reported at 6.6%. The provisional sickness for September 2023 is reported at 6.21% remaining above the 5% standard

Root cause of the performance issue

- High mental health related absence
- High MSK absence
- Increase in Covid related absences

Improvement Actions

- Weekly review of all absences ensuring relevant support in place and recovery focussed.
- Workforce support through short term sickness meetings, long term sickness reviews and workforce triage.
- Early intervention through Locality Workforce, support with PAM referrals and signposting to resources e.g.
    - Support for staff through SPC (Staff Psychological Centre)
    - Promotion of wellbeing conversations, stress risk assessments, carers passports and WRAP plans
- Introduction of ESR Supervisor Self Service (Limited Access)
- PAM DNA exploration.
- Vaccine clinics for flu and COVID-19

Expected impact and by when

- Management increased overview, first point of contact/recording of sickness.
- Keeping staff feeling well at work
- Robust people management processes; including STS monitoring
- Reduction in Occupational Health DNA's
- Increased immunity to flu and COVID-19

P03 - % of Training Compliance (Courses with a Standard)

Risk Rating - **High (Action)**

% of Training Compliance (Courses with a Standard)

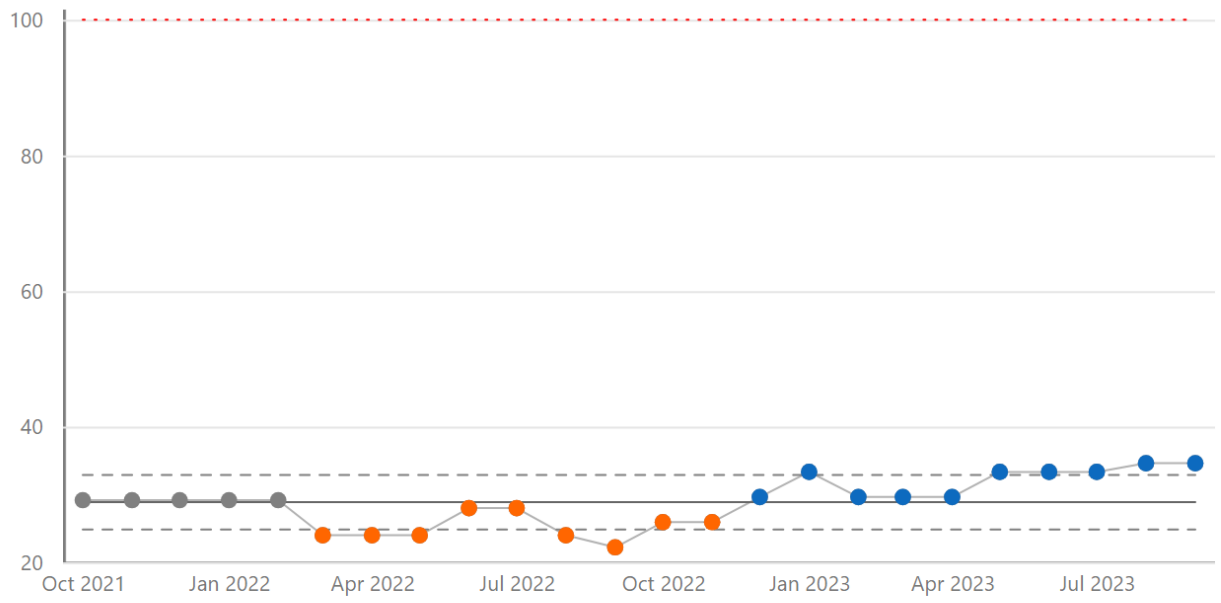
Performance - 34.6%

Standard - 100.0%

Consistently Fail
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	40.0%	100.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	26.9%	100.0%	Improvement	Consistently Fail
North Locality Care Group	44.0%	100.0%	Improvement	Consistently Fail
South Locality Care Group	40.0%	100.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Training Compliance remained at 34.6% for September which is slightly above the expected range of 25% to 33%. It is the tenth successive month where performance was above the mean average. In September, 9 out of 27 training courses with a standard are achieving the required 85% standard.

Root Cause of the performance issue

- Capacity to release staff for training
- Late cancellations due to clinical activity
- Attachment of competencies to staff records - error identified
- Volume of mandatory training requirements
- Increased training competencies with 85% compliance standards

Improvement Actions

- Further updates to competency data
- The Training Needs Analysis tool with the modality of the training used to support planning of training trajectories
- Promotion of the modes of accessing training
- Train the trainer for some core programmes to deliver in place, bespoke training undertaken
- Development of trajectories report with Workforce Information to support setting and monitoring Training Trajectories

Expected impact and by when

- Continued Improvement in Training Trajectories
- Staff feeling competent and safe to undertake role in line with policy and guidance

Training - Summary Overview

Reporting Period: Sep 2023

Great Place to Work - Training

Ref	Indicator Name	Variation	Assurance	Performance	Standard	Numerator	Denominator	Plan	Risk Rating
T01	Training - Clinical Risk and Suicide Prevention	Normal Variation	Consistently Fail	71.6%	85.0%	2111	2948	Internal	High (Action)
T02	Training - Clinical Supervision	Concern	Consistently Fail	76.8%	85.0%	2629	3425	Internal	High (Action)
T03	Training - Equality & Diversity Introduction	Improvement	Consistently Achieve	94.9%	85.0%	9473	9987	Internal	Low (On Track)
T04	Training - Fire	Improvement	Achieve at Random	86.4%	85.0%	8632	9987	Internal	Low (On Track)
T05	Training - Health & Safety	Improvement	Consistently Achieve	93.7%	85.0%	9355	9987	Internal	Low (On Track)
T06	Training - IPC	Improvement	Consistently Achieve	92.9%	85.0%	9280	9987	Internal	Low (On Track)
T07	Training - Medicines Management Training	Concern	Achieve at Random	63.1%	85.0%	1817	2880	Internal	High (Action)
T08	Training - Moving & Handling Awareness Training	Improvement	Consistently Achieve	93.5%	85.0%	9342	9987	Internal	Low (On Track)
T09	Training - PMVA Basic	Improvement	Consistently Fail	57.0%	85.0%	1506	2642	Internal	High (Action)
T10	Training - Rapid Tranquilisation Training	Concern	Consistently Fail	60.6%	85.0%	887	1465	Internal	High (Action)
T11	Training - Safeguarding Adults Level 1	Improvement	Consistently Achieve	95.5%	85.0%	2418	2533	Internal	Low (On Track)
T12	Training - Safeguarding Adults Level 2	Improvement	Achieve at Random	91.3%	85.0%	2671	2927	Internal	Low (On Track)
T13	Training - Safeguarding Adults Level 3	Improvement	Consistently Fail	77.6%	85.0%	3143	4053	Internal	High (Action)
T14	Training - Safeguarding Children Level 1	Improvement	Consistently Achieve	95.6%	85.0%	2421	2533	Internal	Low (On Track)
T15	Training - Safeguarding Children Level 2	Improvement	Consistently Fail	88.1%	85.0%	2578	2927	Internal	Med (Monitoring)
T16	Training - Safeguarding Children Level 3	Improvement	Consistently Fail	80.3%	85.0%	3256	4053	Internal	High (Action)
T17	Training - Information Governance	Improvement	Consistently Fail	91.1%	95.0%	9096	9987	Internal	Med (Monitoring)
T18	Training - Seclusion Training	Concern	Consistently Fail	51.3%	85.0%	1674	3261	Internal	High (Action)
T19	Training - PMVA Breakaway	Concern	Consistently Fail	61.9%	85.0%	2319	3747	Internal	High (Action)
T20	Training - MHA MCA DoLS Combined	Normal Variation	Consistently Fail	63.1%	85.0%	4116	6520	Internal	High (Action)
T21	Training Resuscitation L2 Adult Basic Life Support	Normal Variation	Consistently Fail	48.9%	85.0%	842	1721	Internal	High (Action)
T22	Training Resuscitation L2 Newborn Basic Life Support	Normal Variation	Consistently Fail	0.0%	85.0%	0	28	Internal	High (Action)
T23	Training Resuscitation L2 Paediatric Basic Life Supp	Normal Variation	Consistently Fail	17.7%	85.0%	135	762	Internal	High (Action)
T24	Training Resuscitation L3 Adult Immediate Life Supp	Improvement	Consistently Fail	56.0%	85.0%	1859	3320	Internal	High (Action)
T25	Training Resuscitation L3 Paediatric Immed Life Supp	Normal Variation	Consistently Fail	0.0%	85.0%	0	268	Internal	High (Action)
T26	Training - Autism Core Capabilities: Tier 1 & 2	SPC N/A		49.6%	85.0%	499	1007	Internal	High (Action)
T27	Training - Learning Disability Tier 1	SPC N/A		51.3%	85.0%	517	1007	Internal	High (Action)

P04 - Appraisal rate

Appraisal rate

Risk Rating - **High (Action)**

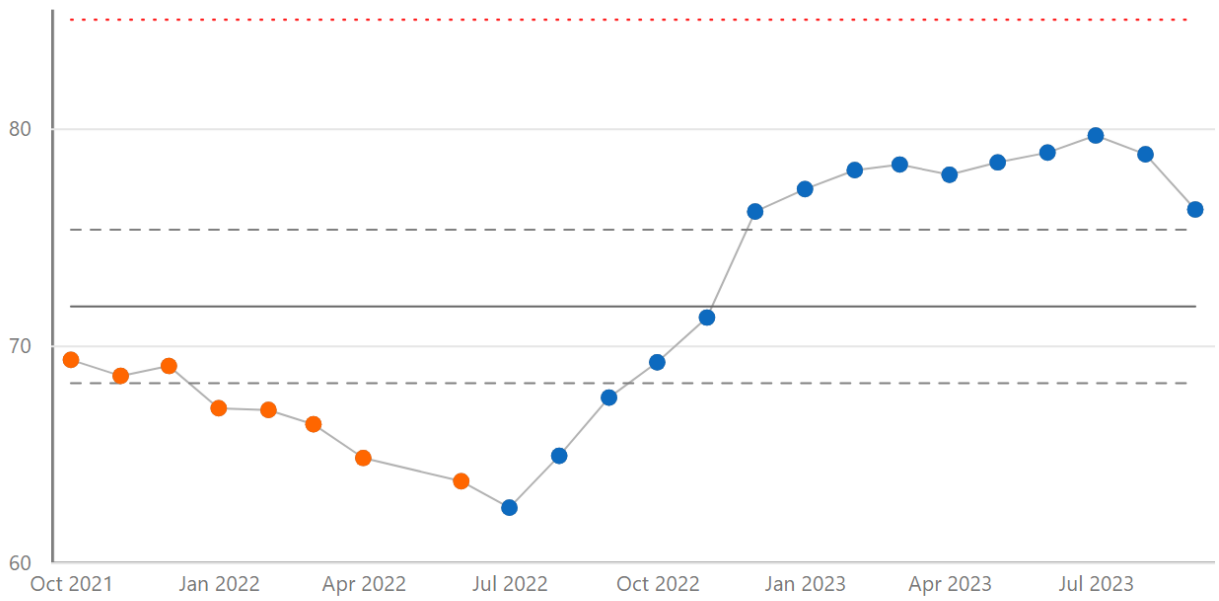
Performance - 76.3%

Standard - 85.0%

Consistently Fail
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	75.3%	85.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	72.2%	85.0%	Improvement	Consistently Fail
North Locality Care Group	74.2%	85.0%	Improvement	Consistently Fail
South Locality Care Group	81.5%	85.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

The appraisal rate was 76.3% in September, the tenth consecutive month higher than the mean average.

Root cause of the performance issue

- Capacity to prepare and undertake appraisal – staffing pressures
- Backlog from pandemic pause
- Late cancellations due to clinical capacity

Improvement Actions

- Promotion through CBU meetings and Workforce Triage
- Discussions around capacity and appropriate support, considering delegation.

Expected impact and by when

- The aim is for all staff to have an appraisal during 23/24 as this is linked to a CQC must do.

P05 - % Clinical Supervision completed

Clinical Supervision

Risk Rating - **High (Action)**

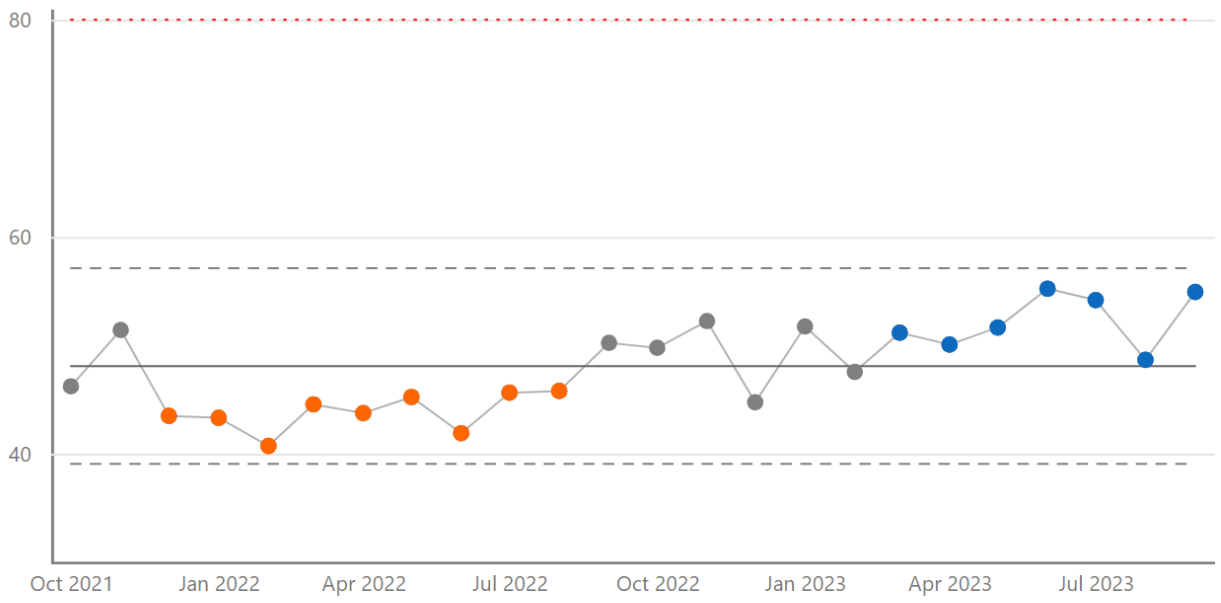
Performance - 54.9%

Standard - 80.0%

Consistently Fail
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	57.9%	80.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	45.9%	80.0%	Normal Variation	Consistently Fail
North Locality Care Group	54.4%	80.0%	Normal Variation	Consistently Fail
South Locality Care Group	63.3%	80.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Performance of 54.9% in September was consistent with the expected range of 39% to 57%

Root cause of the performance issue

- Capacity to release staff to undertake supervision – staffing pressures
- Late cancellations due to clinical capacity
- Recording of clinical supervision that has been undertaken

Improvement Actions

- Monitored through local CMT and QS&O meetings within CBU's
- Setting expectations with CBU leadership team and re-embed
- Establishing and removing barriers to recording and solutions to data issues, working with the CNTW Training Academy
- Directive for Clinical Supervision to be a priority focus

Expected impact and by when

- The aim is for all staff to have an appraisal during 23/24 as this is linked to a CQC must do.
- Staff opportunity for reflection and shared learning
- Staff feeling empowered and competent in undertaking their role

Q01 - Restrictive intervention incidents

Risk Rating - Med (Monitoring)

The number of restrictive intervention incidents - Cause group of Blanket Restriction/ Restrictive Practice

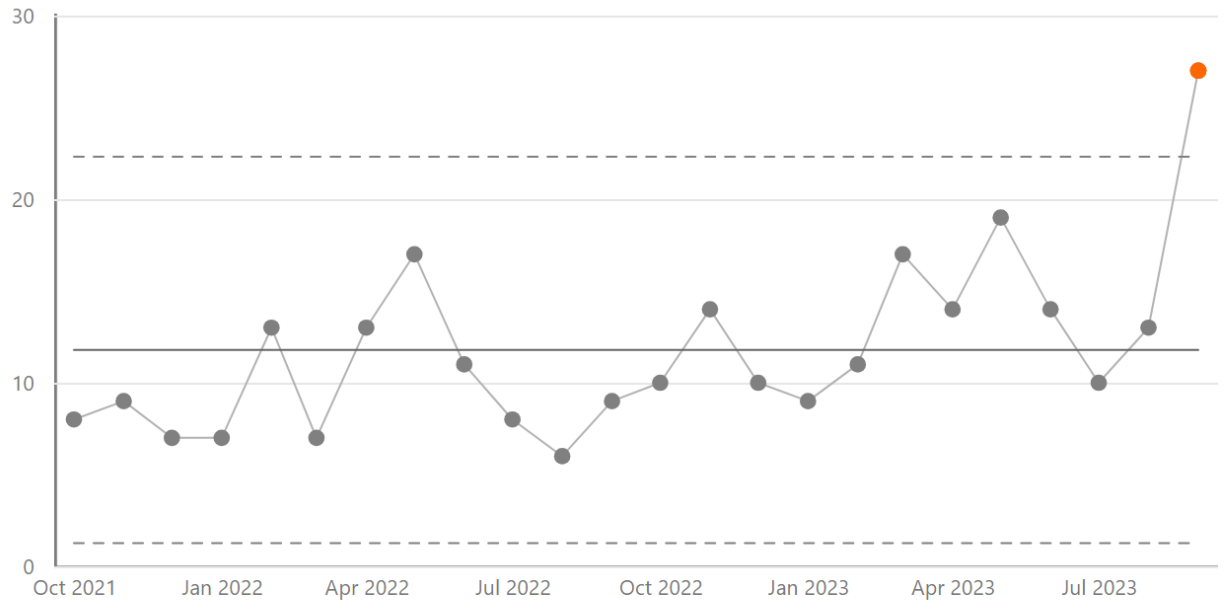
Performance - 27

Standard - No Std

No Standard
Assurance cannot be given for this indicator as there is no standard set

Concern
There is concern because this indicator is increasing

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	5	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	5	No Std	Normal Variation	No Standard
North Locality Care Group	12	No Std	Concern	No Standard
South Locality Care Group	5	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

The number of restrictive intervention incidents increased in the month

Root Cause of the performance issue

The North locality has had an increased number of blanket restriction / restrictive practice incidents this month. 50% of these relate to restrictions required to support safe management of a specific individual patient. The number of recurrent incidents reported demonstrates that the incidents are reviewed regularly and used for the short term and then reinstated if required to manage risks.

Improvement Actions

All blanket restrictions and restrictive practice are regularly reviewed by teams, CBUs and localities.

Expected impact and by when

The number of incidents will fluctuate there is oversight on all individual incidents

Q02 - Serious Incidents

Number of Serious Incidents

Risk Rating - **High (Action)**

Performance - 24

Standard - No Std

No Standard

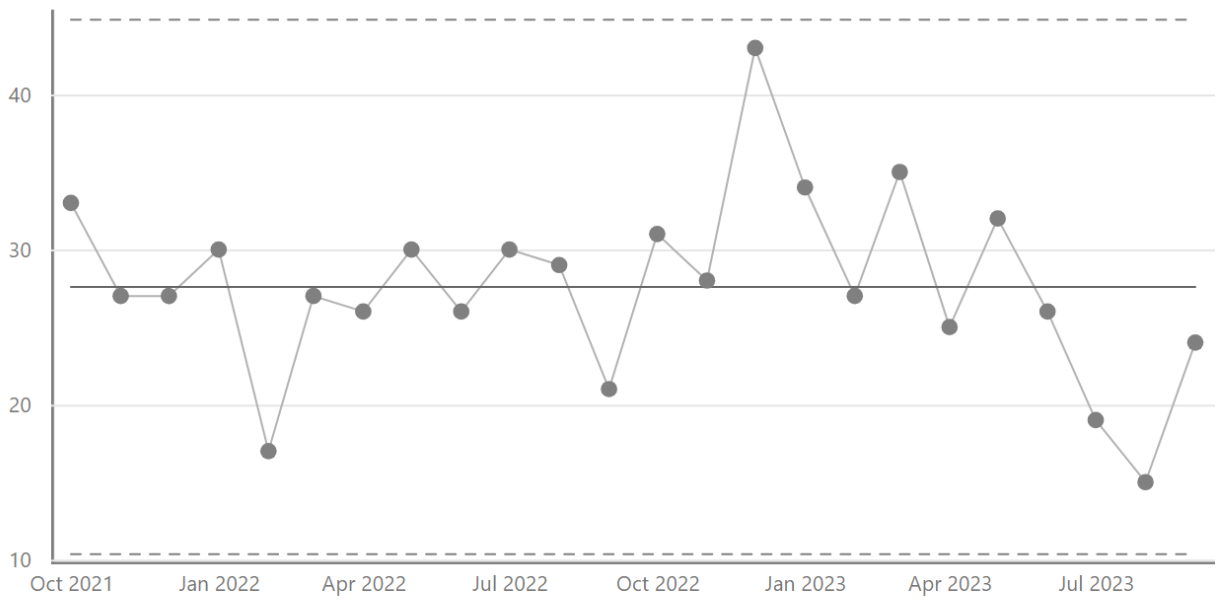
Assurance cannot be given for this indicator as there is no standard set

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	11	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	7	No Std	Normal Variation	No Standard
North Locality Care Group	4	No Std	Improvement	No Standard
South Locality Care Group	2	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

24 serious incidents were recorded within September. That is consistent with the expected range of 10 and 45 serious incidents per month.

Root Cause of the performance issue

There is no significant variation in the trend for the last two years. September's figures are below the monthly average but an increase from previous months. This measure is being included in this report due to the significance and magnitude of these incidents.

Improvement Actions

Each serious incident is subject to an investigation which identifies areas of learning and recommendations. This forms an action plan and is subject to Trust and ICB governance processes to ensure that learning is embedded.

The Trust and ICB approach to Serious Incident investigation is currently under review as part of PSIRF implementation planning.

Expected impact and by when

Planned timescale for PSIRF implementation / transition is currently to start in November 2023

Q04 - Safeguarding and Public Protection (SAPP)

Safeguarding and Public Protection (SAPP)

Risk Rating - Med (Monitoring)

Performance - 1,394

Standard - No Std

No Standard

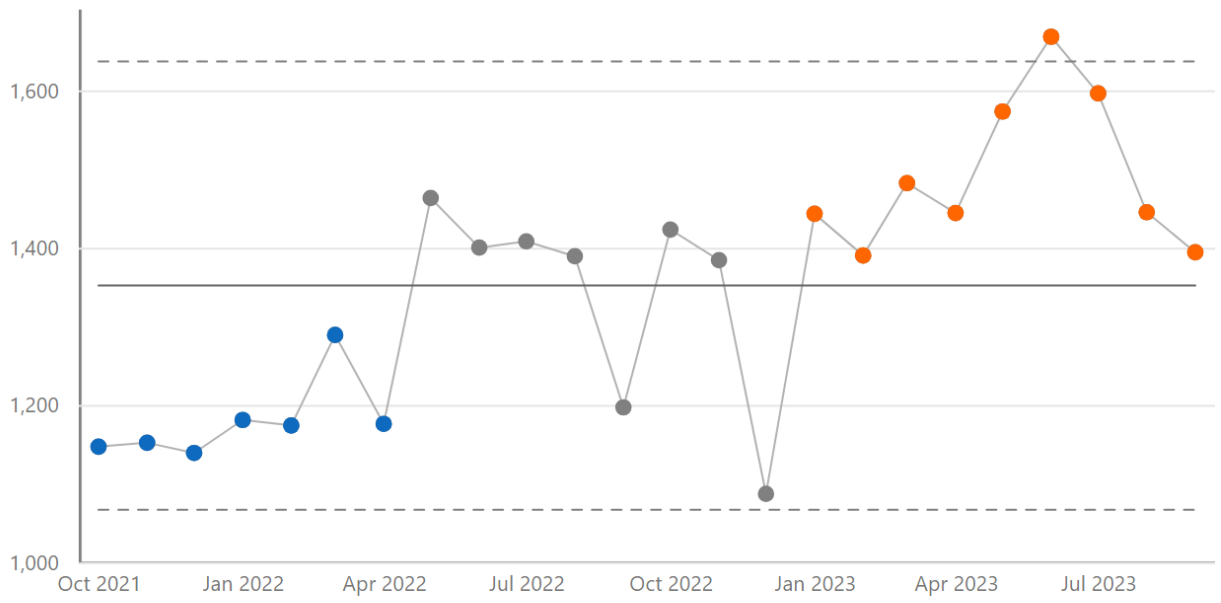
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is increasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	446	No Std	Concern	No Standard
North Cumbria Locality Care Group	179	No Std	Concern	No Standard
North Locality Care Group	419	No Std	Concern	No Standard
South Locality Care Group	334	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Reported safeguarding activity fell to 1,394 in September. It is within the expected range, but as it is the ninth successive month above the mean average there is a suggestion of a possible underlying cause.

Root Cause of the performance issue

Increased safeguarding reporting generally is in line with national trends and linked to greater awareness because of the rollout of level 3 training.
In addition, the expected impact of focussed work of the SAPP team is felt to have increased reporting in some localities.

SAPP Triage have highlighted that not all safeguarding incident reports are categorised correctly, and better data is required to enable analysis of safeguarding reporting

Improvement Actions

SAPP team continue to have oversight of all reported safeguarding incidents and continue to provide support advice and supervision where required across all clinical localities.
An amendment to the data recording of outcome options via SAPP triage is to be implemented to better understand potential issues with reporting that may be impacting increased safeguarding figures and potentially reducing figures in other incident categories such as Violence and Aggression.

Expected impact and by when

Identification of inaccurate reporting will allow targeted training and improvement around Safeguarding incident reporting to take place. Trial of additional outcome measure from triage ongoing and will run till end Q2.

Q06 - Aggression and Violence

Aggression and Violence

Risk Rating - Med (Monitoring)

Performance - 1,419

Standard - No Std

No Standard

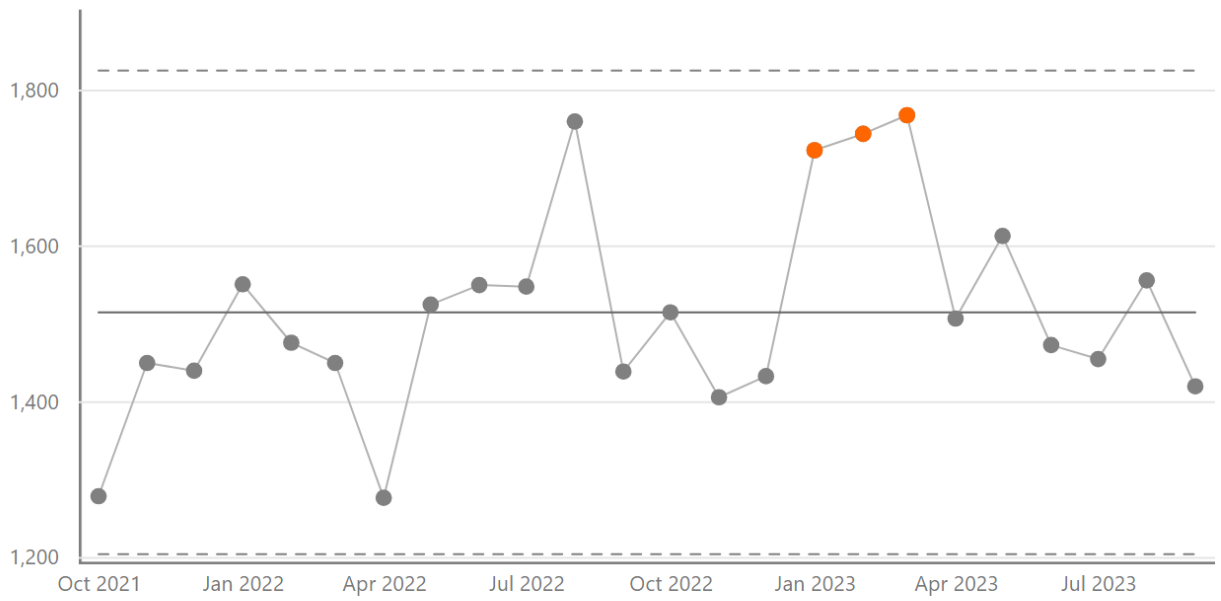
Assurance cannot be given for this indicator as there is no standard set

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	236	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	359	No Std	Normal Variation	No Standard
North Locality Care Group	449	No Std	Normal Variation	No Standard
South Locality Care Group	370	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 1,419 recorded incidents of aggression and violence during September which falls within the calculated expected range of 1,204 and 1,824 incidents.

Root Cause of the performance issue

September activity for aggression and violence is lower than the same period last year and is also the lowest reported this financial year, against a backdrop of overall incident increase for the month of September. It can still be seen from assessing the data that the high reporting areas of the Trust continue to be autism in-patient services and children's in-patient services, but even these areas are accounting for a reduction in incidents from the same period last year. In line with developments for the PSIRF plan, aggression and violence is an incident category that will be subject to a greater level of review as it still accounts for every third incident reported in the Trust.

Improvement Actions

To support the PSIRF plan the new talk 1st dashboard will be available in October and shared with all clinicians to use in individual care planning.

Expected impact and by when

Aggression and violence incidents will continue to be reviewed but greater quality data available via dashboards is helping to focus down to individual patient activity.

Q08 - Care Plans compliance

Care Plans compliance

Risk Rating - Med (Monitoring)

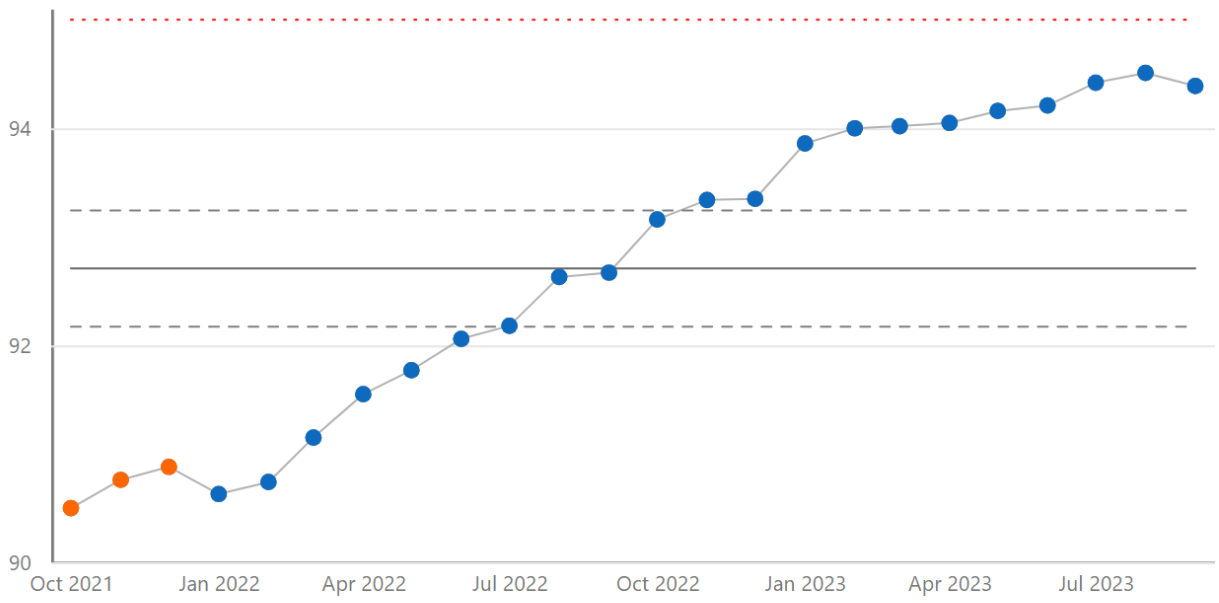
Performance - 94.4%

Standard - 95.0%

Consistently Fail
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	96.2%	95.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	86.7%	95.0%	Improvement	Consistently Fail
North Locality Care Group	96.6%	95.0%	Improvement	Consistently Achieve
South Locality Care Group	93.6%	95.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

Performance of 94.4% in August remained below the standard of 95% and fell a little from the previous month.

Significant improvement in Central Locality due to embedding regular monitoring processes and improved management of floating caseloads in CTT's.

Root Cause of the performance issue

Care plan compliance metric is attached to services which don't use care plans such as IRS and PLT

Care plans discussions with patients and carers are completed but not recorded on RiO accurately.

Improvement Actions

Services under the 95% threshold are reviewing care plans, to ensure they are correctly reflecting the work undertaken with patients and carers. When it is identified that care plans needs updating, this work is undertaken.

As a result of feedback, a metric review will identify if there is better measure or improvements which can be made to the current measure.

Care Plan Form - Refresher training to remind staff where the tick box is housed within Rio that requires updating to identify the care plan has been discussed with the service user.

Expected impact and by when

The focus area of improvement is within our community treatment teams, this work, alongside the metric review is expected to end in March 2023.

Q10 - CPA Completed review

Risk Rating - High (Action)

Number of current Service Users, aged 18 or over, who were on CPA for at least 12, who have had a review in the last 12 months.

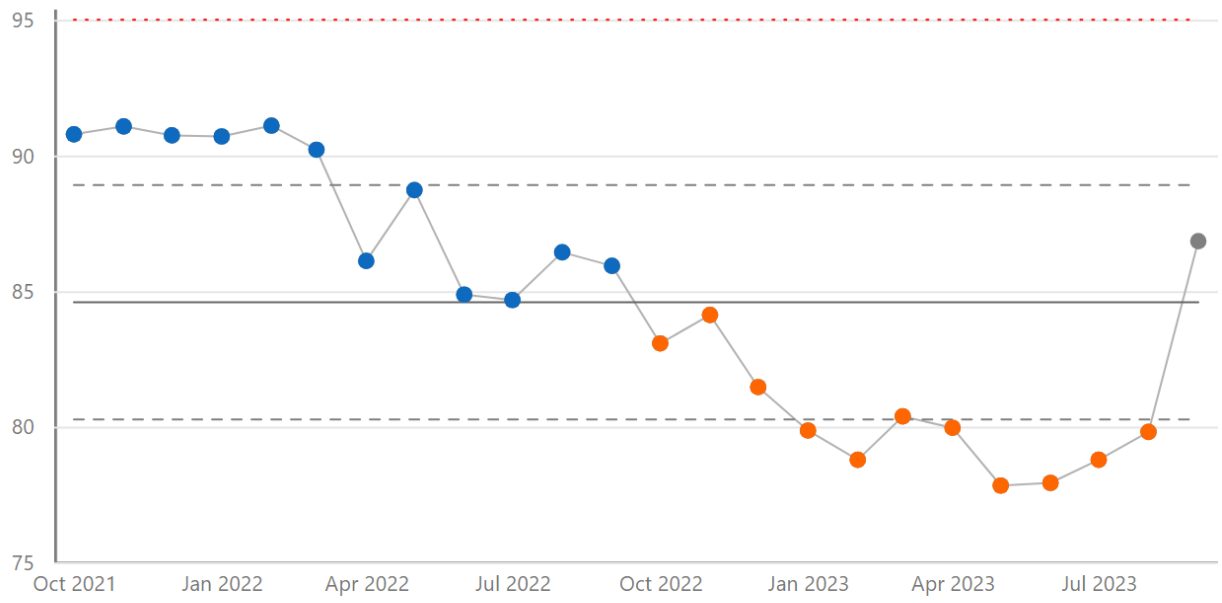
Performance - 86.8%

Standard - 95.0%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	91.6%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	66.7%	95.0%	Normal Variation	Consistently Fail
North Locality Care Group	97.1%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	88.2%	95.0%	Concern	Achieve at Random

Feedback

What the chart tells us

- CPA completed reviews increased by over 7% to 86.8% for September, though it remained below the 95% standard.

Root Cause of the performance issue

- Until recently CPA was identified within the South Community CBU risk register due to significant staffing pressures, which saw the CPA metric compliance fall, particularly associated with medication pathways. May see a further decline with the introduction of 7 Pioneer Teams moving away from CPA to an updated set of metrics related to Dialog and other outcome measures. Several teams included in this metric are not responsible for CPA reviews and the clients which are flagging are open to other teams. This is particularly problematic for trustwide teams such as adult ADHD and ASD which hold large waiting lists.

Improvement Actions

- Monthly case management supervision. Weekly reports generated by pathway co-ordinators to flag any out of date CPA or upcoming CPA reviews
- Inpatients have developed process as part of 72 hour review meeting to support. Introduction of new process for booking medic reviews
- Focussed work undertaken within Commissioning and Quality Assurance Data Quality staff to review the data via the dashboard metric and update RiO where applicable

Expected impact and by when

- The standard was achieved in the North Locality in September, with the expectation this is sustained. Improvements have resulted from weekly exception reporting. A negative impact on CPA metrics may be seen, related to the community transformation process, as the work with the 7 Pioneer Teams is rolled out.

Q11 - Staffing fill rates

Staffing fill rates - All day/night and Reg/Unreg

Risk Rating - **High (Action)**

Performance - 143.1%

Standard - 120.0%

Achieve at Random

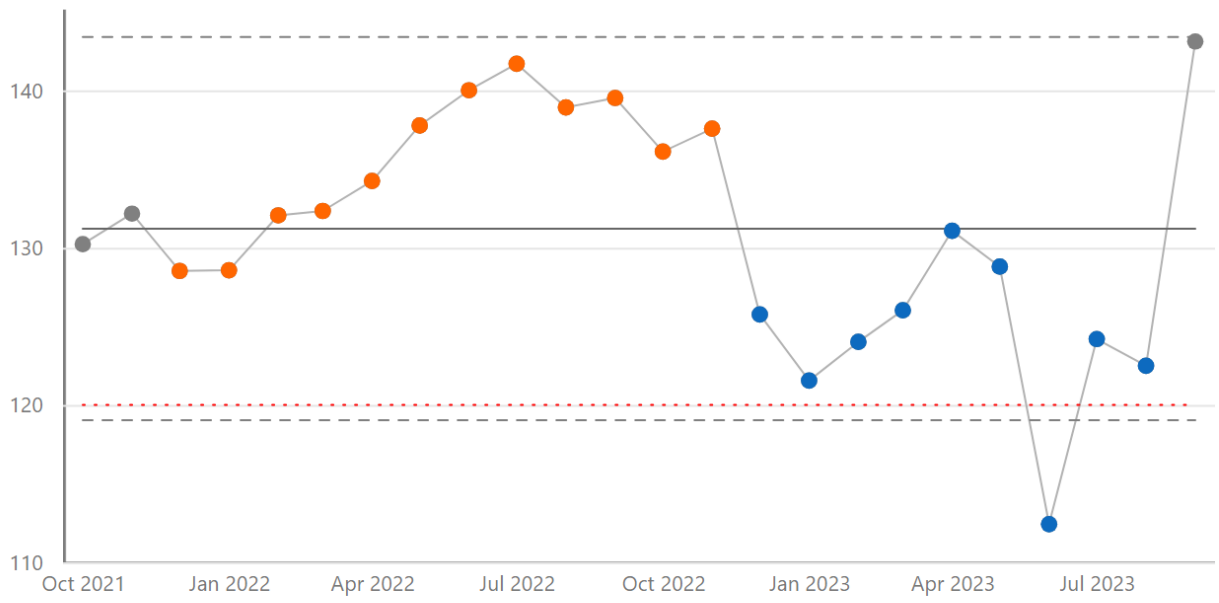
The standard for this indicator is within the upper and lower control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	162.3%	120.0%	Concern	Achieve at Random
North Cumbria Locality Care Group	145.2%	120.0%	Normal Variation	Achieve at Random
North Locality Care Group	108.2%	120.0%	Improvement	Achieve at Random
South Locality Care Group	153.9%	120.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Staffing fill rate was 143.1% in September 2023, reported at the upper limit of the expected range.

Root Cause of the performance issue

There remain vacancies across inpatient services.

South, Central and North Cumbria are consistently failing to have staffing fill rates less than 120% affecting the overall performance of this measure.

Reporting this month is now via a manual collection for all areas with the exception of North Cumbria and Lotus ward which are using allocate system for bank and agency and substantive rostered staff, therefore data quality may be impacted requiring further investigation to confirm accuracy via the wards.

Improvement Actions

Recruitment activities continue.

Rollout of new shift allocation software across wards.

Reviews of all agency usage.

Inpatient Staffing – Enhanced MDT Model work is progressing as part of the Urgent Care Programme Board. The outcome will produce a revised skill mix model for Adult Acute wards. Timeframe for completion end of Q3

Expected impact and by when

That there is a safe reduction in agency and locum usage during 2023/24, alongside an increase in the number of substantive CNTW staff working on the wards.

A01 - Out of Area Placement bed days

Out of Area Placement bed days

Risk Rating - **High (Action)**

Performance - 249

Standard - 135

Achieve at Random

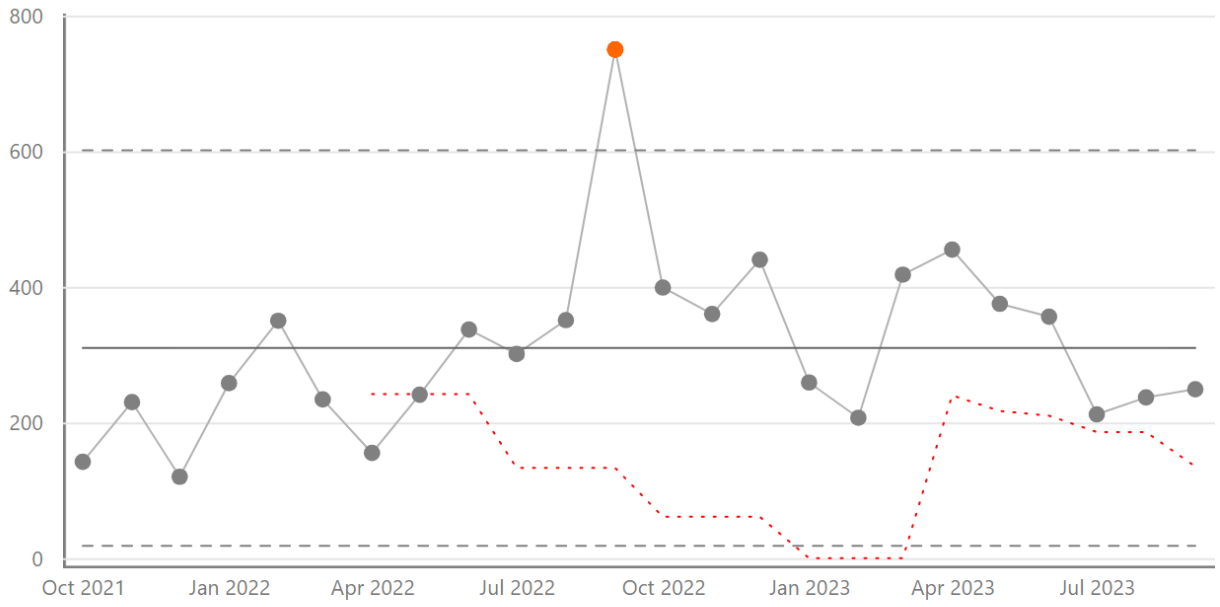
The standard for this indicator is within the upper and lower control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	110	No Std		No Standard
North Cumbria Locality Care Group	25	No Std		No Standard
North Locality Care Group	57	No Std		No Standard
South Locality Care Group	57	No Std		No Standard

Feedback

What the chart tells us

There were a total of 249 Out of Area Placement bed days reported in September relating to 15 patients all within the adult acute pathway. The locality breakdown is based on the patients' home address.

Root Cause of the performance issue

Patients needing an inpatient admission when there are no appropriate CNTW beds available. The main pressure continues to be within Adult Acute beds.

Impacted by number of patients who are clinically ready for discharge within CNTW beds

Improvement Actions

EBM have staff allocated to each of the 4 localities in the adult pathway. These staff monitor and support any Out Of Area patients from their locality, attending meetings and reviewing them remotely as needed. EBM have the local knowledge of services and processes to give the patients the same support as they would get if in a CNTW bed. On occasion when we do have Older Adults out of area our OP Staff support these in the same way also. EBM meet collectively as a team once per week. This includes the clinical manager, Team Manager and a staff member from each locality to update on progress of the OOAs. This meeting offers collective discussion on a plan for each patient and allows us to flag anyone as a priority for repatriation or escalate any cases for additional support. This model allows collective understanding of the current OOAs to a level of detail that allows us to know who we are looking to repatriate first when a bed is available. EBM are continuously refining the process for OOA but feel this process is having a positive impact on OOA numbers and LOS.

Expected impact and by when

The ambition is to record zero OOA placements by the end of Q4 2023/24

A02 - Bed Occupancy including leave (open beds on RiO)

Risk Rating - **High (Action)**

Bed Occupancy including leave (open beds on RiO)

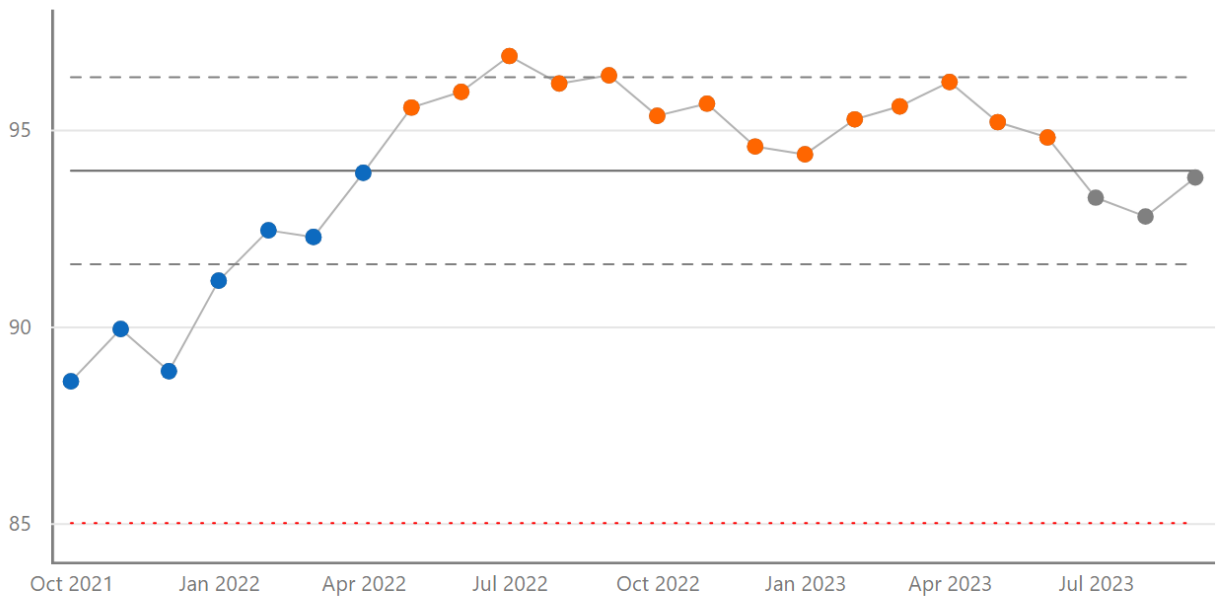
Performance - 93.8%

Standard - 85.0%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	93.0%	85.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	85.8%	85.0%	Normal Variation	Achieve at Random
North Locality Care Group	96.6%	85.0%	Improvement	Consistently Fail
South Locality Care Group	95.8%	85.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Bed occupancy increased by 1% to 93.8% which is within the expected range of 91.6% to 96.3%, which is higher than the optimal level of 85%.

Root Cause of the performance issue

More bed days are used than originally planned. Bed occupancy remains over standard which is reflective of the national picture and pressures.

Impacted by number of patients who are clinically ready for discharge (CRFD) within CNTW beds

Improvement Actions

An exercise to map potential additional bed capacity has been completed, this considered where we can add more bed capacity across CNTW. Localities are working closely with the bed management team to try to ensure that local leadership team have oversight and influence around acuity and level loading.

Each locality has a CRFD meeting in place involving LA, EBM and IP services to review CRFD and determine what is preventing the discharge. The Trust has consulted on a Trust wide PGN in managing CRFD

EBM continue to support wards via the discharge facilitators allocated to each locality. Case managers are in place to support discharges for more complex patients. ICB established a ICB CRFD support meeting to support complex system wide discharges.

Expected impact and by when

It is anticipated that bed occupancy will remain above the optimal level of 85% over the winter period. Positively, the actions outlined above will sustain bed occupancy within the expected range.

A05 - Clinically Ready for Discharge (formerly DTOC)

Risk Rating - High (Action)

Percentage of patients clinically Ready for Discharge (formerly DTOCs) at the end of the month (Q&P Metric 298: Current Delayed Transfers of Care days (Incl Social Care)

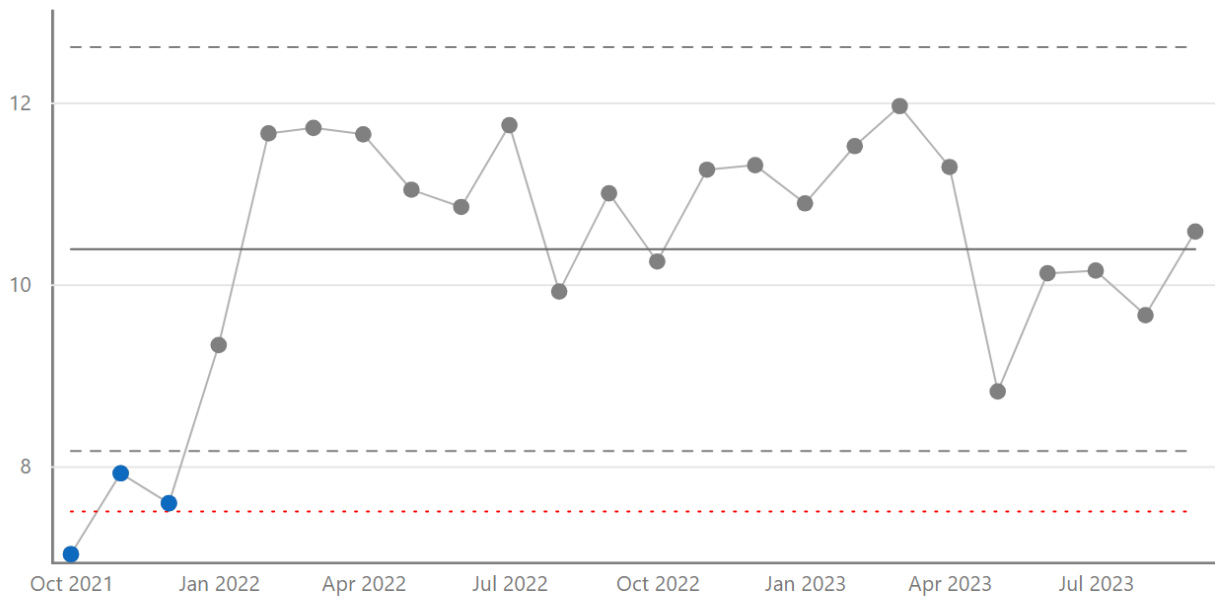
Performance - 10.6%

Standard - 7.5%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6.6%	7.5%	Concern	Consistently Achieve
North Cumbria Locality Care Group	23.1%	7.5%	Normal Variation	Consistently Fail
North Locality Care Group	10.6%	7.5%	Normal Variation	Consistently Fail
South Locality Care Group	10.1%	7.5%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In September 10.6% of patients were clinically ready for discharge, which is within the expected range of 8.2% to 12.6%

Root Cause of the performance issue

The availability of onward discharge destinations for patients that are clinically ready for discharge; delays caused by health (such as care agreements) or social care (such as housing). North Cumbria has long standing issues regarding the availability of onward discharge destinations for patients that are clinically ready for discharge.

Improvement Actions

- Fortnightly CRFD meeting with Local Authority & ICB place commissioners to discuss those CRFD. Discharge plan for each patient is place supporting their timely discharge from the point of admission including daily flow meetings.
- Red and Green Bed Days being rolled out in all Acute Wards at St Georges Park (piloted in Warkworth, go live for Embleton 16.10.23, go live for Alnmouth 30.10.23).
- Mitford & Mitford Bungalows – continue to action OBD price increases for lack of engagement in discharge planning for those CRFD.
- Introduction of ICB meetings with a focus on specific pathways to commence in South Locality on 17th October 2023

Expected impact and by when

It is anticipated that CRFD will remain above the optimal level of 7.5% over the winter period, however the actions above are expected to maintain performance within the expected range.

A06 - Crisis % Very urgent seen within 4 hours (WAA&OP)

Risk Rating - Med (Monitoring)

% of referrals (Adults and OA) with a priority of Very Urgent who have an attended Direct Contact within 4 hours following receipt of the referral

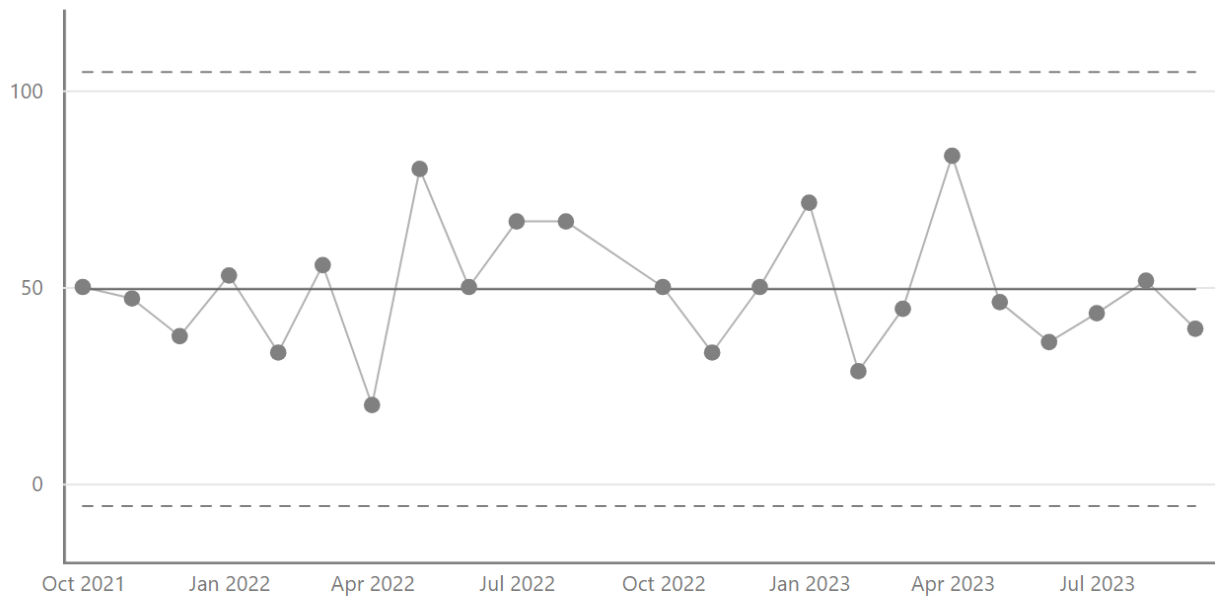
Performance - 39.4%

Standard - No Std

No Standard
Assurance cannot be given for this indicator as there is no standard set

Normal Variation
The variation for this indicator is within the control limits

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	40.0%	No Std		No Standard
North Cumbria Locality Care Group	36.8%	No Std		No Standard
North Locality Care Group	0.0%	No Std	Normal Variation	No Standard
South Locality Care Group	66.7%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Very Urgent referrals seen within 4 hours decreased to 39.4% in September.

Root Cause of the performance issue

The root cause of the issue, as discussed at the monthly crisis and liaison waiting time meeting, is a mix of data quality concerns regarding the interpretation and recording of 'Very Urgent' referral types between teams and service capacity.

Improvement Actions

- Access Oversight Group re-established and meeting monthly. Crisis Recording Guidance being reviewed and updated to support consistency of recording across Localities.
- The Access Oversight Group will be reviewing the metric to ensure it is consistent across the ICB and in line with the new national measures for Crisis and Home Treatment services.
- Refresher Training for localities in terms of recording expectations.
- North Crisis team reviewing MDT process and HBT review process.
- Teams are reviewing when and how they use 'Very Urgent' to improve consistency across all the Crisis teams.

Expected impact and by when

Timeframe provided by localities at the crisis and liaison waiting time meeting details that this work is to be completed by March 2024, this will improve how we responding to people in crisis.

A07 - Crisis % Urgent seen within 24 hours (WAA&OP)

Risk Rating - Med (Monitoring)

% of Urgent referrals to crisis service seen within 24 hours (Adults and OA)

Performance - 80.6%

Standard - No Std

No Standard

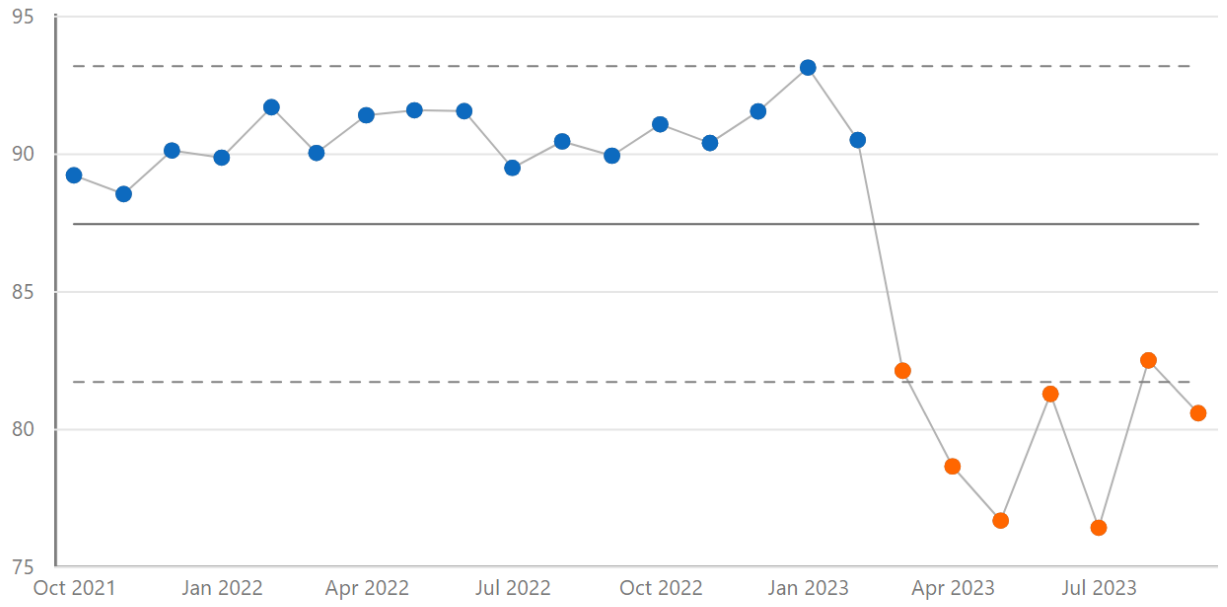
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	79.3%	No Std	Concern	No Standard
North Cumbria Locality Care Group	81.7%	No Std	Concern	No Standard
North Locality Care Group	68.3%	No Std	Normal Variation	No Standard
South Locality Care Group	90.1%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Urgent referrals seen within 24 hours increased to 80.6% in September, taking it again below the expected lower limit of 81.6% and suggesting an underlying change.

Root Cause of the performance issue

The root cause of the issue, as discussed at the monthly crisis and liaison waiting time meeting, is a mix of data quality concerns regarding the interpretation and recording of 'Urgent' referral types between teams and service capacity.

Improvement Actions

- Access Oversight Group re-established and meeting monthly.
- Crisis Recording Guidance being reviewed and updated to support consistency of recording across Localities.
- Refresher Training for North team in terms of recording expectations.
- North Crisis team reviewing MDT process and HBT review process.
- The Access Oversight Group will be reviewing the metric to ensure it is consistent across the ICB and in line with the new national measures for Crisis and Home Treatment services.
- Central Locality in discussions with commissioners re provision of older people's crisis for Gateshead as CNTW does not provide the community or inpatient service.

Expected impact and by when

- Timeframe provided by localities at the crisis and liaison waiting time meeting details that this work is to be completed by March 2024, this will improve how we responding to people in crisis.

A08 - % PLT ED Referrals seen within 1 hour

Risk Rating - **Med (Monitoring)**

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

Performance - 63.4%

Standard - No Std

No Standard

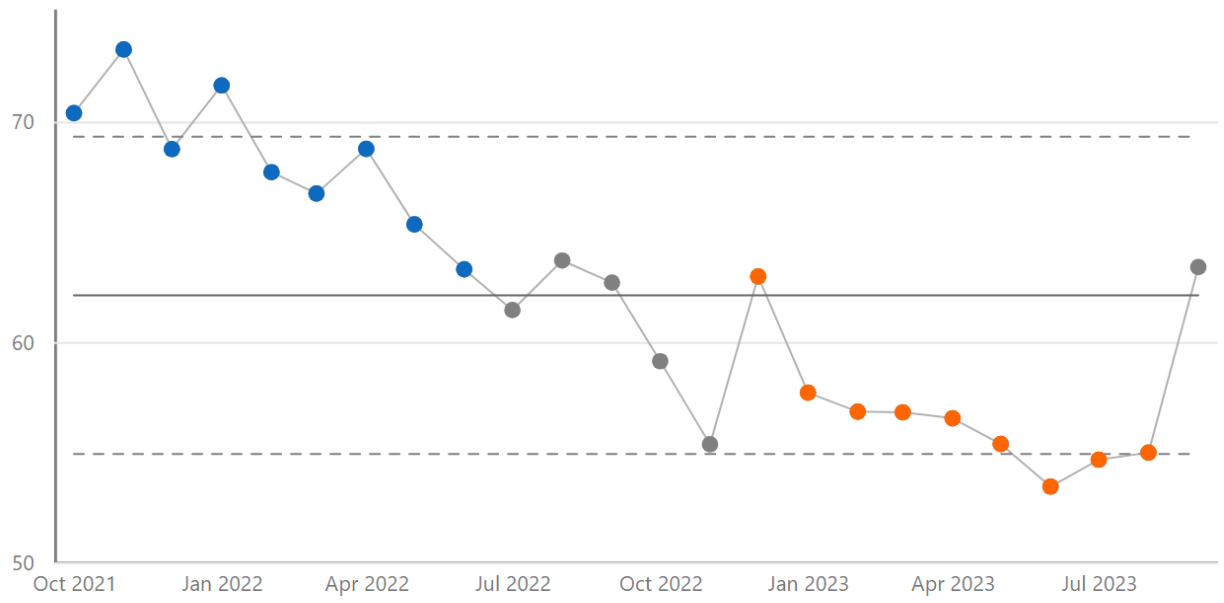
Assurance cannot be given for this indicator as there is no standard set

Normal Variation

The variation for this indicator is within the control limits

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	59.9%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	63.6%	No Std	Normal Variation	No Standard
North Locality Care Group	46.9%	No Std	Normal Variation	No Standard
South Locality Care Group	80.2%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Performance was 63.4% in September which was within the expected range of 54% to 69%. and is reported for the 1st time in the last 9 months above the mean average of 62.1%.

Root Cause of the performance issue

- Issue with ED staff referring to PLT when patient is not medically fit, patients having physical needs seen to or they refuse to be seen which then causes breach of target.
- The challenges remain mainly within North locality. Central have seen a significant increase in the month, with the South and North Cumbria performing in line with national averages
- Staffing (recruitment/retention/sickness) remains a challenge.

Improvement Actions

- Trust Innovation Group supported by a Clinical Lead have reviewed practices and supported improvement across all Localities
- Ensuring there is a consistent and embedded approach to recording practices
- Incorrect appointment recording which impacts on performance
- Providing recording guidance to liaison teams when the patient is unable to be seen, but there is an active referral been made to the team.
- Review of all breaches to identify any themes that can be fed into the AOG guidance review
- Specific to North locality:
    - Progressing with the implementation of digital dictation and efficient ways of accessing the acute trusts patient electronic record system
    - Establishment of a shift co ordinator role commencing in October 2023
    - Discussions taking place with NSECH regarding referrals to PLT

Expected impact and by when

- Improvement work remains ongoing, and improvements anticipated within Q3

A11 - % Waiting 4 wks or less to treatment (WAAOP)

Risk Rating - **High (Action)**

The number of service users waiting 4 wks or less to treatment (New National Methodology July 2023)

Performance - 24.6%

Standard - No Std

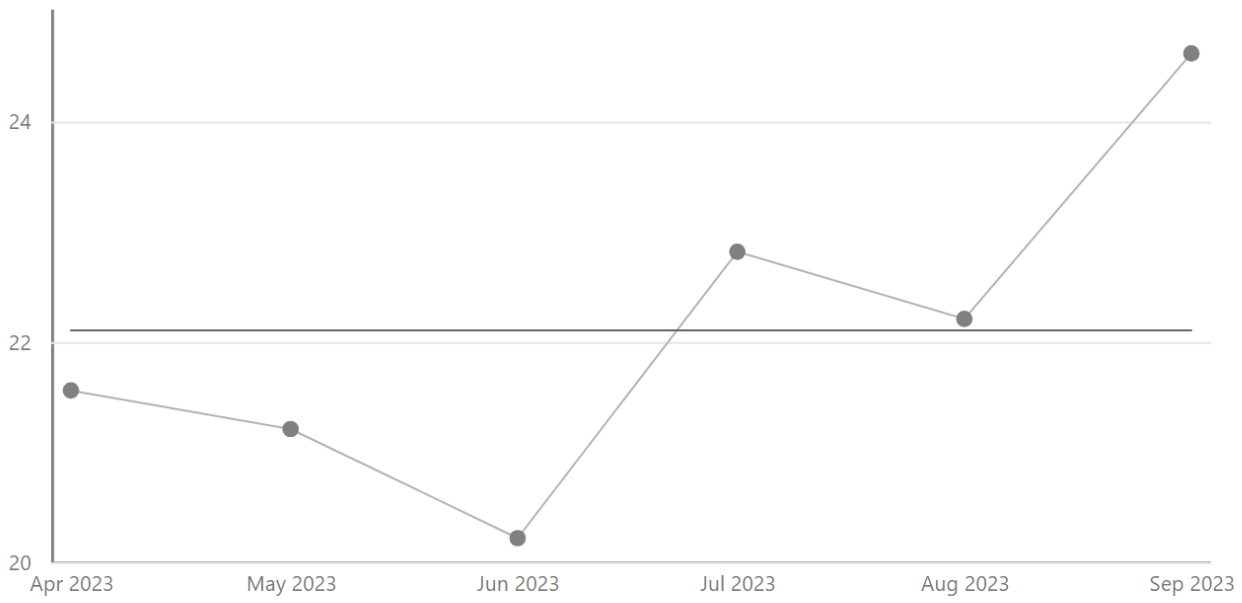
No Standard

Assurance cannot be given for this indicator as there is no standard set

Variation SPC Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	38.0%	No Std		No Standard
North Cumbria Locality Care Group	11.9%	No Std		No Standard
North Locality Care Group	36.8%	No Std		No Standard
South Locality Care Group	24.2%	No Std		No Standard

Feedback

What the chart tells us

In September 24.6% of referrals are reported to have been waiting 4 weeks or less to treatment.

Root Cause of the performance issue

Data Quality issues

The root cause differs across teams, issues such as demand for assessment and the capacity of assessment slots, data recording and practice.

Improvement Actions

Teams included have been reviewed in October and where applicable inclusions and exclusions to be made to both internal metrics and weekly proformas to reflect accurate data

Ongoing communication and embedding of the 4WW recording requirements and continue to use monthly Performance Clinics to review each Teams position.

Two weekly waiting list meetings for oversight that waiting times are sustaining

Monthly feedback an update to oversight group.

Sunderland continues to work with Every Turn waiting list initiative.

Improving the length of time to complete an assessment.

Counsellors have been employed within the South Locality to support treatment pathways.

Trust wide task and finish group to support accurate and standardised service specification and the work with the Community Transformation programme.

Engaged in wider Community Transformation developments.

Expected impact and by when

Focused Quality Improvement work supported by monthly community steering group and progress fed back into Community Oversight Group.

A12 - % Waiting 4 wks or less to receive help (CYPS)

Risk Rating - High (Action)

The number of service users waiting 4 wks or less to receive help (New National Methodology July 2023)

Performance - 9.5%

Standard - No Std

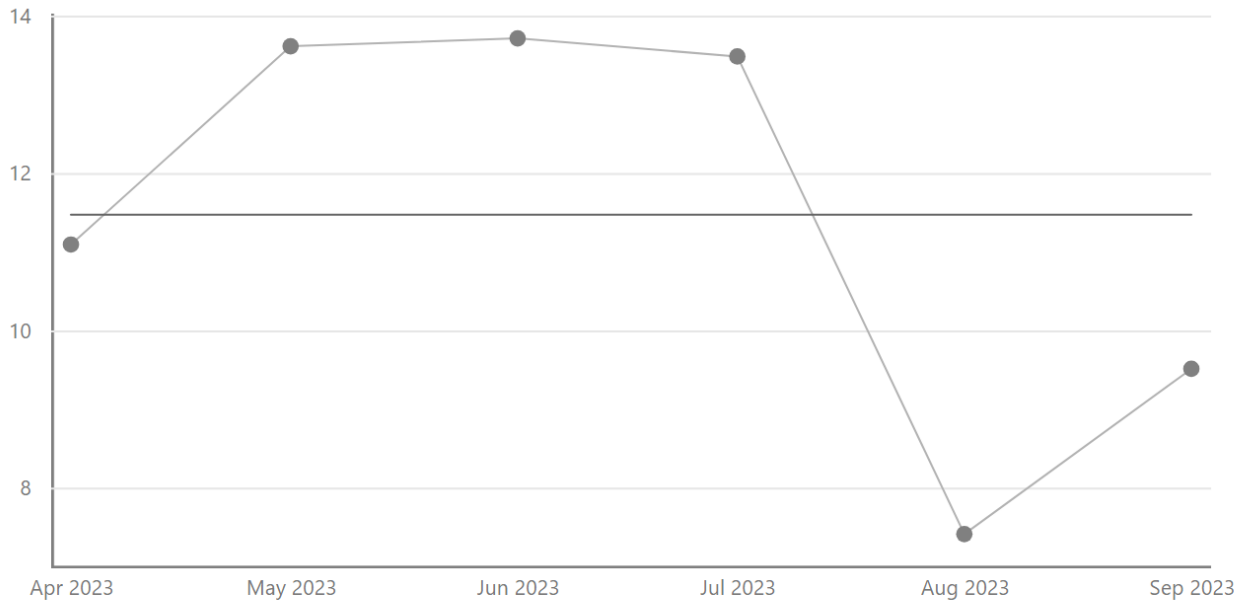
No Standard

Assurance cannot be given for this indicator as there is no standard set

Variation SPC Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6.9%	No Std		No Standard
North Cumbria Locality Care Group	4.6%	No Std		No Standard
North Locality Care Group	49.3%	No Std		No Standard
South Locality Care Group	50.7%	No Std		No Standard

Feedback

What the chart tells us

In September 9.5% of referrals are reported to have been waiting 4 weeks or less to receive help.

Root Cause of the performance issue

Demand increasing following school holidays. South Locality continue to show sustained improvement. Waits for neurodevelopmental services.

Improvement Actions

There is a significant focus and action in place regarding CYPS waiting times as a key priority area for improvement, these are discussed and learning shared at the Access and Waiting Times Group.

South Locality Quality Improvement work.

Pilot for Multi-agency triage at School to support directing referrals to other partner agencies to meet needs.

Engagement with place-based commissioner around system wide approach.

North Locality CYPS – Ongoing communication and embedding of the 4WW recording requirements and continue to use monthly Performance Clinics to review each Teams position.

Expected impact and by when

Pathways for CYPS are expected to be impacted following on from the volume for work underway, while referrals do increase just prior and during school holidays the plan is record a reduction in the number of CYPS waiting by March 2024.

A13 - % Waiting 4 wks or less to receive help (CYPS Neuro)

Risk Rating - High (Action)

The number of service users waiting 4 wks or less to receive help (New National Methodology July 2023)

Performance - 6.2%

Standard - No Std

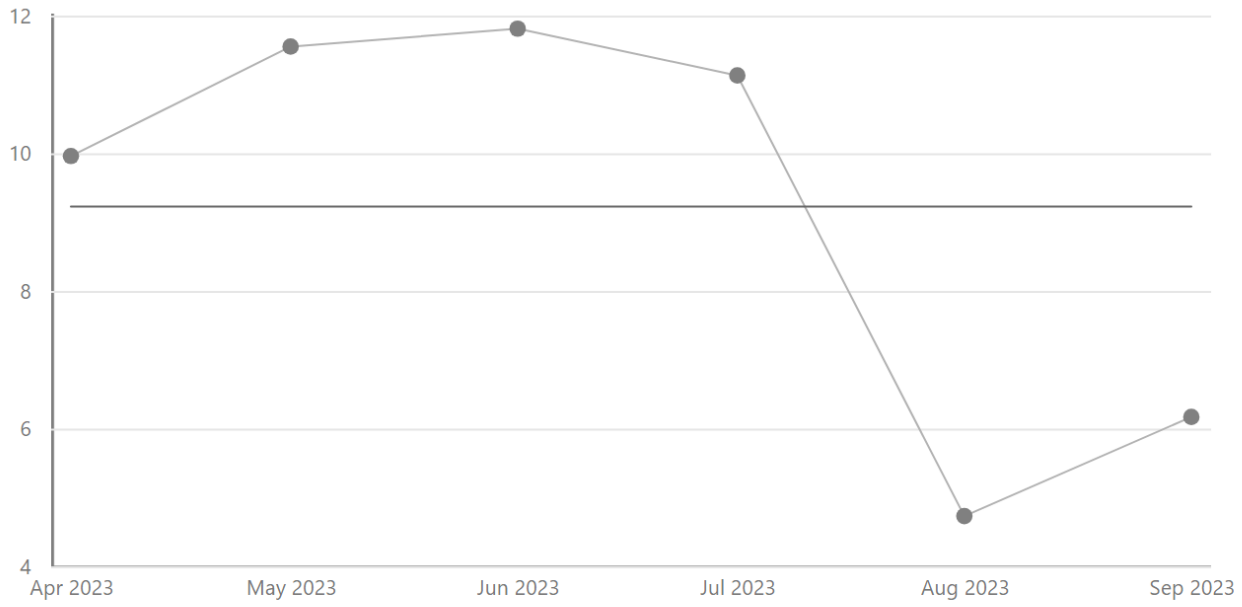
No Standard

Assurance cannot be given for this indicator as there is no standard set

Variation SPC Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	4.2%	No Std		No Standard
North Cumbria Locality Care Group	2.7%	No Std		No Standard
North Locality Care Group	42.1%	No Std		No Standard
South Locality Care Group	50.0%	No Std		No Standard

Feedback

What the chart tells us

In September 6.2% of referrals are reported to have been waiting 4 weeks or less to receive help.

Root Cause of the performance issue

Demand is currently outstripping capacity. Number of different access routes within CNTW. Guidance has been received regarding the international shortage of ADHD medications, suspending current titrations.

Improvement Actions

Trustwide Task and Finish group focusing on review overall pathway and access to CNTW

'Stop the line' process as agreed within Task and Finish groups, to support moving young people through the pathway and reducing 'floating caseload' to improve position to support with back log.

South Locality have moved from 60+ young people to 4 over that time frame

Introduction of multi-agency welcome events to support young people in accessing appropriate support to meet their needs whilst awaiting assessment

Welcome Event frequency needed in each geographical area is being reviewed.

Expected impact and by when

Impact on waits has not yet been seen. Unlikely to see significant impact whilst awaiting implementation of new referral guidance and process and shortage of ADHD medications.

A15 - CYPS Eating Disorders (routine referrals)

Risk Rating - **Med (Monitoring)**

Percentage of eating disorder CYPS referrals that waited <= 4 weeks routine completed (Q&P Metric 1865)

Performance - 93.3%

Standard - 95.0%

Achieve at Random

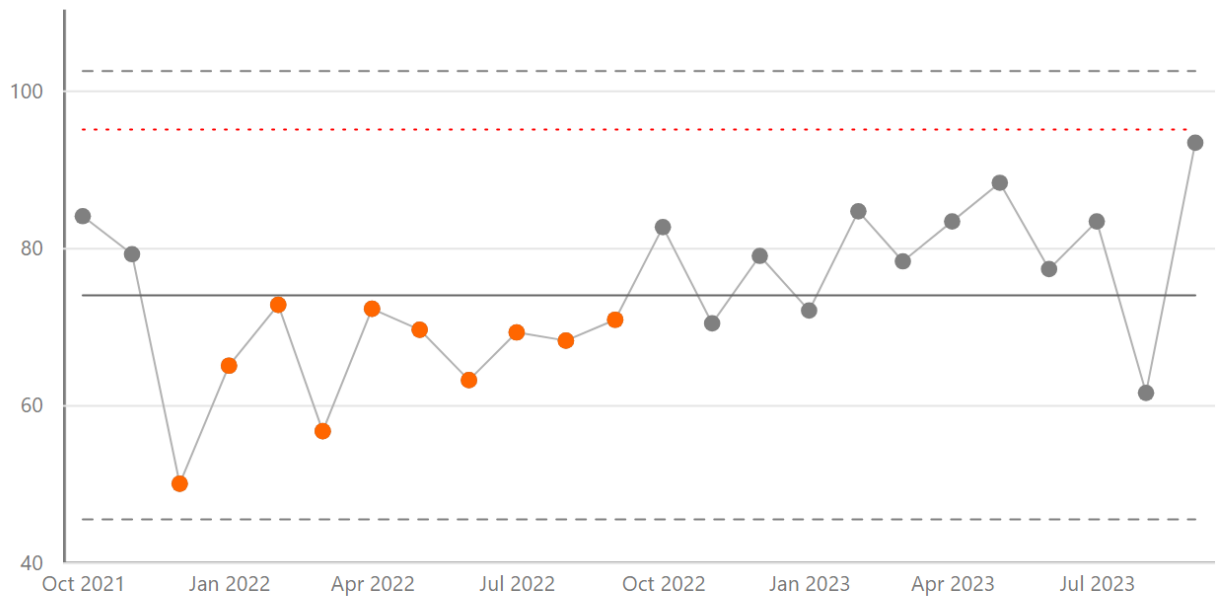
The standard for this indicator is within the upper and lower control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	100.0%	95.0%		
North Cumbria Locality Care Group	93.3%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	100.0%	95.0%		
South Locality Care Group	0.0%	95.0%		

Feedback

What the chart tells us

93.3% of routine referrals waited <4 weeks in September, which is within the expected range of 45% and 100%. This range suggests that the standard of 95% will rarely be achieved.

Root Cause of the performance issue

Demand is currently outstripping capacity.

Improvement Actions

Internal operational changes to the organisational structure are being considered to improve oversight.

There are differences regarding how services are commissioned, resourced and delivered across the ICB, the services have been engaging with the ICB to develop recommendations to improve CYPS ED services across the area. CNTW are currently waiting for the outcome of the presented recommendations to the ICB.

Expected impact and by when

The waits for routine eating disorders have improved, the expected improvement will lead to more consistent service delivery, operational function and oversight. The change is anticipated to happen during Q4.

S01 - Live within our means (I&E Surplus/Deficit £)

Live within our means (I&E Surplus/Deficit £)

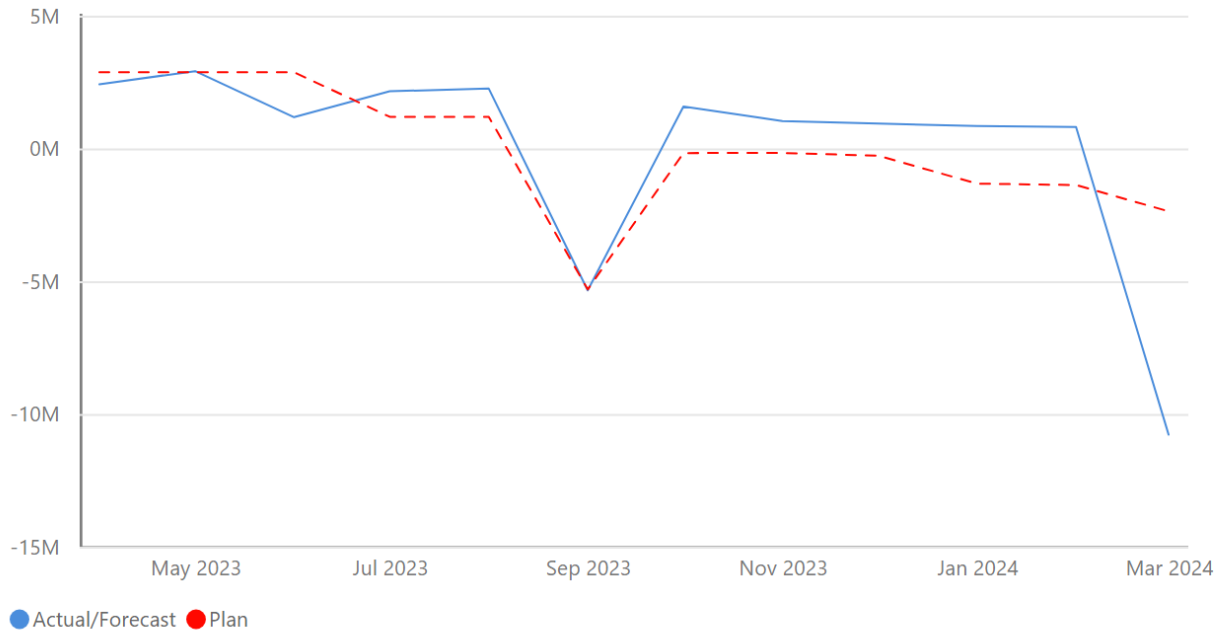
Risk Rating - **High (Action)**

Actual/Forecast - -5.3M
Plan - -5.31M

Assurance SPC Not Applicable

Variation SPC Not Applicable

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality Name	Off Budget (£1,000)
Central	310
North	226
North Cumbria	-85
South	-146
Corporate	-341

Feedback

- Budget overspends across clinical groups (North & Central highlighted) driven from ward over establishments.
- Overspends across Corporate budgets, over established staffing budgets.

Improvement Actions

- BDG monthly finance focus sessions to agree actions to impact on the Trust financial position and review of progress to deliver the Trust Cost Improvement Plan.
- Groups / Departments highlighted areas under review to impact on financial performance. BDG discussions to clarify where they improve financial forecast.
- Daily staffing reviews taking place across inpatient areas.
- Agreement of financial trajectories to deliver financial break-even.
- Pursing capital funding for CEDAR scheme to support Trust cash balances

9. ANNUAL SAFETY, SECURITY AND RESILIENCE REPORT 2022/23

(INCLUDING EPRR REPORT CORE STANDARDS ASSESSMENT)

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

9. Safety Security and Resilience Annual Report - 2022 - 2023 Board Nov 23.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**2022 / 23 Annual – Safety, Security and Resilience Report (Including EPRR Core Standards Assessment)**
Executive Lead	**Ramona Duguid – Chief Operating Officer**
Report author	**Tony Gray – Associate Director of Safety, Security and Resilience**

Purpose of the report	
To note	
For assurance	**x**
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	x
2. Person-led care, when and where it is needed	x
3. A great place to work	x
4. Sustainable for the long term, innovating every day	x
5. Working with and for our communities	x

Meetings where this item has been considered	
Quality and Performance	x
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
People	
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience	x	Service user, carer and stakeholder involvement	x

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. SA4 Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.

Board of Directors
Wednesday 1st November 2023

2022 / 23 Annual – Safety, Security and Resilience Report
(Including EPRR Core Standards Assessment)

1. EXECUTIVE SUMMARY

The purpose of this report is to provide assurance around the systems of work in place overseen by the Trust's Safety, Security and Resilience Team, this report also serves as an assurance around our current compliance with the NHS England Emergency Preparedness, Resilience and Response Core Standards.

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

The Health and Social Care Act 2022 requires all NHS organisations to plan for and respond to a wide range of incidents that could impact on health or patient care. This includes significant incidents or emergencies such as prolonged periods of pressure on services, extreme weather conditions, infectious disease outbreaks or a major transport accident. The programme is referred to as (EPRR).

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

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

The Trust has in place an Accountable Emergency Officer, this role is undertaken by the Chief Operating Officer. This role was supported by the Director of Safety, Security and Resilience and the Safety, Security and Resilience Team.

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

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

2. BACKGROUND

The portfolio of the team covers the following corporate responsibilities.

Health and Safety

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

Security Management

- Overseeing the Security Strategy of the Trust
- Monitoring Security Contracts
- Monitoring the Secure Transport Contracts
- Setting standards of CCTV and ensuring compliance / supporting clinical services with CCTV Evidence
- Management of the Lone Working System within the Trust
- Management of Body Worn Cameras within in-patient services.

Emergency Preparedness, Resilience and Response

- Planning, reviewing and implementing Emergency Planning arrangements
- Reviewing and updating guidance in respect of Heat Health Alert Planning
- Reviewing and updating guidance in respect of The Adverse Weather Plan
- Working in partnership with our ICS Resilience Team / Local Health Resilience Partnership
- Working in partnership with NHS England regional and national EPRR Teams

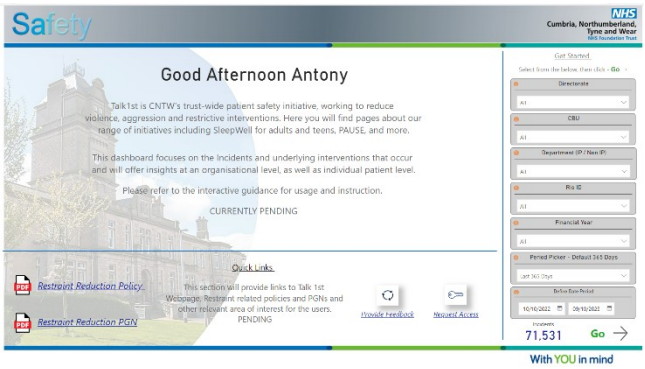
3. KEY ISSUES, SIGNIFICANT RISKS AND MITIGATIONS

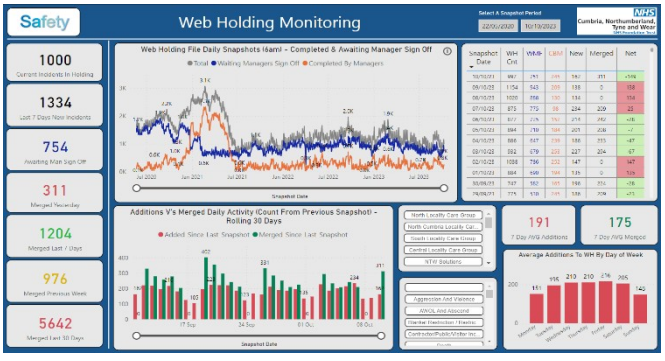
3.1 Incident Reporting

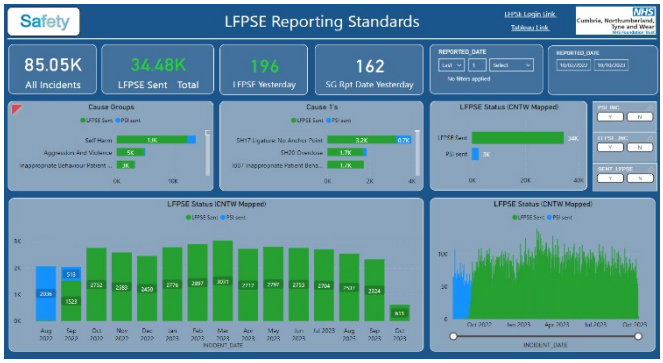
The Trust's incident reporting system is the foundation of activity that drives improvement and learning across the organisation, and the team oversees the Trust's Local Risk Management Software – Ulysses (Safeguard system). The system is used to record, report, and manage the Trust's serious incident, incident and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 activity, the latter specifically to the Health and Safety Executive.

Over the last year the Trust has embedded its reporting into the Learning From Patient Safety Events system, being one of the pilot organisations. This system will replace two national outdated information systems the National Reporting and Learning Service and the Strategic Executive Information System (STEIS) which are both over 20 years old. Whilst the system had been delayed for a number of reasons , Trust and other healthcare providers have been transitioning to this new national system throughout 2022 / 23 with an expected plan that all organisations have completed the task by the 30th September, as a pilot organisation who went live in September 2022, we have shared our learning with a number of NHS organisations through podcasts and live video presentations at the request of NHS England, to date we have reported over 30,000 incidents through the new national system, and are engaged with NHS England on a number of other development projects.

To support with the Trusts agenda of reflection and learning the Safety, Security and Resilience Team, has been supporting subject experts across the Trust with more detailed analysis with a number of interactive dashboards, which is allowing more intuitive analysis of data. These are currently being rolled out across the Trust and will embed into practice over the next year. This also allows us to reflect on our national data. This will also support the transition plan into our Patient Safety Incident Response Framework as it allows analysis of a number of incidents across patient pathways and services and the types of incidents. This data is also supporting the more detailed analysis of activity that is being updated into the Integrated Performance Report.







There are no significant risks relating to this activity. We are fully compliant with the national requirement to transition.

3.2 Lone Working

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

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

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

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

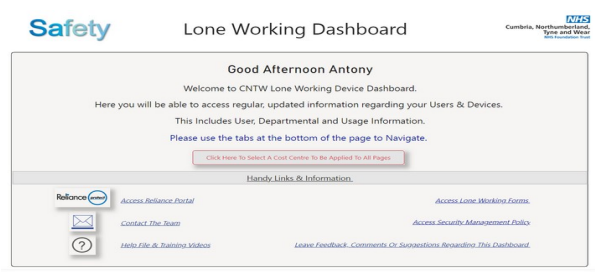
Lone working ID Badge used by Community Staff

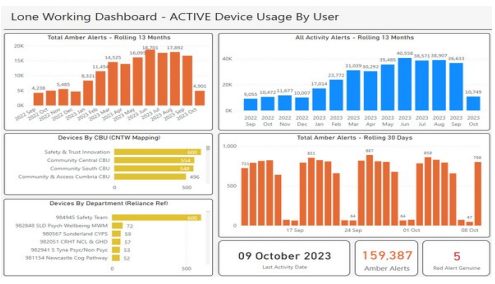
Pulse device used in reception areas of community services

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

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

Throughout the last year we have transitioned all lone workers to the latest GPS enabled technology, and swapped out over 2,000 devices, this has allowed us to fully analyse usage for each of the lone workers and do a full system check, this has also resulted in an improvement in usage, as some outdate devices have been replaced. The below shows the improvements to usage over the last year.





If system used and operated correctly there are no significant risks relating to this activity.

3.3 Tackling Illicit Drug Use / Narcotics Search Dogs

The use of illicit drugs continues to be a problem in some inpatient settings. A number of serious incidents have occurred relating directly to consumption of illicit substances both on the ward and following an episode of leave, media reports and national research have continued to highlight the problem the North East is facing. The Trust isn't an outlier in this, and the Trust continues to support a Service Level Agreement to provide a service in partnership with Tees, Esk and Wear Valley NHS Foundation Trust. We have 2 Search Dog Handlers and Search dogs working across the whole North East and North Cumbria ICS and working closely with respective Police Forces that cover the geographical locations, to identify trends and report activity, sharing intelligence of vehicles that come onto Hospital sites and known sellers of illicit substances. In order to understand activity, we have integrated our internal systems to provide up to information in relation to the activity that we experience across the Trust and the ICS. Below is a representative sample of the information we have and can share with our Police colleagues.

The Service Level Agreement (SLA) with our neighbouring Trust comes to an end in March 2024 and we have taken a decision after discussion with our Directors to terminate the SLA to concentrate our efforts within our own Trust, to have a more significant impact in detecting and reducing this risk.

By reducing the support for the SLA for another Trust we can concentrate the resource in the Trust and further reduce risk for the patient population.

3.4 Clinical Environmental Safety Group

The Trust has in place the above group which is informed from the work carried out by the Safety, Security and Resilience Team undertaking Clinical Environmental Risk Assessments across in-patient services and 136 facilities. It is also informed through its terms of reference by incident, complaints and claims activity, regulation 28 prevention of future death reports and risks that present across the organisation and any national alerting / learning available.

It is currently overseeing and number of workplans in relation to improvements in the in-patient environment including but not limited to the following:

- Implementation of ligature reduction en-suite doors
- Implementation of digitally enabled metal detectors
- Implementation of Oxe-health and relationship to other safety systems.
- Standardisation of Staff attack and nurse call systems.
- Implementation of CCTV on all in-patient wards.
- Review of door access systems for patients.
- Review of ligature reduction bedroom doors and alarm mechanisms

It is acknowledged that a number of these schemes and assessments will take a number of years and is strategically built into the capital planning considerations of the organisation.

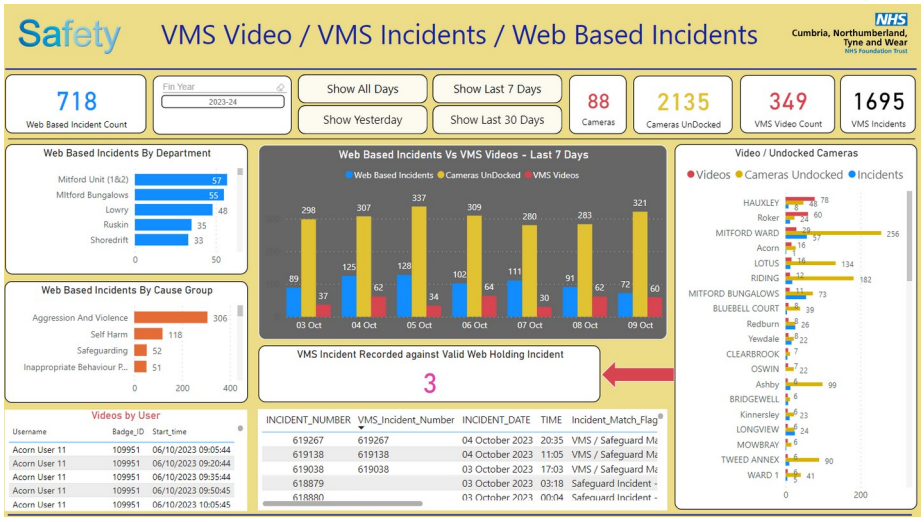
We have taken the opportunity as a learning organisation to create a simulation suite within the Safety Team's offices so that we can review all the latest technology available to reduce harm to patients and see how the systems holistically integrate and work together to support the human processes of engagement and observation and promote recovery for patients.

This environment continues to develop and is being installed with the latest technology to help the Trust learn from incidents and understand when they are reported, how they happened and whether they can be prevented in future.

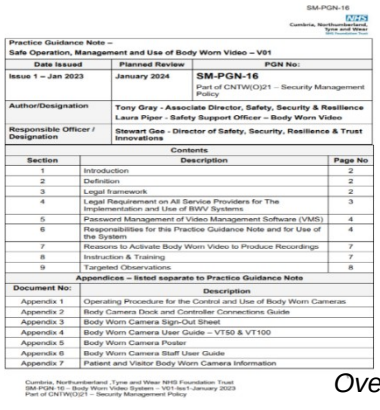
This approach is helping the care groups to mitigate a number of significant risks predominantly on in-patient wards.

3.5 Body Worn Video

The Safety Team supports the safe operation, management and use of body worn video within the Trust and over the last year with the implementation of new guidance for staff we have seen the systems further embed within in-patient wards , and evidence from camera recordings are now routinely used , along with CCTV and now more than ever services should be transparent in the care that is provided, and where concerns are reported, if evidence is available, it can be used for debrief, reflection and any appropriate action required. In line with the strategy of being able to assess the impact of implementation, the Safety Team has developed a dashboard that specifically assesses the impact of body worn video systems in comparison to incident activity in the services where it is located. We have seen steady increase in the data and usage of devices. A recent internal audit report returned a response of reasonable assurance which would be expected as we still embed the system within the Trust. The Trust is about to undertake a pilot in relation to similar cameras that are operated by the Police Service in our children's services to see if they give us any better information and learning from incidents.



The Trust's new Practice Guidance Note has drawn on wider experiences of Police in both local and national guidance and is in principle aligned to the Mental Health Units (Use of Force) Act 2018. As it is implemented it will be an expected standard of use for staff to wear and use cameras in defined incidents such as Police intervention etc. The guidance also includes the requirements for staff to respond to disclosure requests by patients or their representatives for any recordings made, subject to any redaction requirements.


Practice Guidance Note –
Safe Operation, Management and Use of Body Worn Video – V01

Date Issued	Planned Review	PGN No:
Issue 1 – Jan 2023	January 2024	SM-PGN-16 Part of CNTW(O)21 – Security Management Policy
Author/Designation	Tony Gray - Associate Director, Safety, Security & Resilience Laura Piper - Safety Support Officer – Body Worn Video	
Responsible Officer / Designation	Stewart Gee - Director of Safety, Security, Resilience & Trust Innovations	

Contents

Section	Description	Page No
1	Introduction	2
2	Definition	2
3	Legal framework	2
4	Legal Requirement on All Service Providers for The Implementation and Use of BWV Systems	3
5	Password Management of Video Management Software (VMS)	4
6	Responsibilities for this Practice Guidance Note and for Use of the System	4
7	Reasons to Activate Body Worn Video to Produce Recordings	7
8	Instruction & Training	7
9	Targeted Observations	8
Appendices – listed separate to Practice Guidance Note		
Document No:	Description	
Appendix 1	Operating Procedure for the Control and Use of Body Worn Cameras	
Appendix 2	Body Camera Dock and Controller Connections Guide	
Appendix 3	Body Worn Camera Sign-Out Sheet	
Appendix 4	Body Worn Camera User Guide – VT50 & VT100	
Appendix 5	Body Worn Camera Poster	
Appendix 6	Body Worn Camera Staff User Guide	
Appendix 7	Patient and Visitor Body Worn Camera Information	

There are no significant risks relating to this activity.

4. EMERGENCY PLANNING, RESILIANCE AND RESPONSE (EPRR)

EPRR is supported across the Trust by the Safety, Security and Resilience Team, it is not a dedicated function of the team, and work is prioritised in line with all other operational pressures and activities the team deals with on a daily basis both locally and nationally.

It is important to recognise from a resource perspective that this additional function was as a direct result of previous efficiencies and is kept under constant review.

There are 3 members of staff who support the EPRR agenda within the team, the Associate Director, Safety, Security and Resilience Manager and the EPRR Support Officer.

4.1 EPRR – Policy and Guidance

There were minor changes to the Trust's Emergency Preparedness, Resilience and Response Policy – NTW (O)08 in to reflect the change of Director lead. There were also updates to both the Adverse Weather Plan and the Heat Health Alert Plan to reflect changes from national documents from the UK Health Security Agency (UKHSA).

4.2 EPRR Locally and Nationally

The Integrated Care System is now fully operational with a fully funded Resilience Team, this now creates a two-tier management system for provider organisations, with both the ICS team and the NHS England EPRR team which has been strengthened both locally and nationally since the pandemic, sharing information and gathering intelligence and data requests in relation to providers business activity.

4.3 Industrial Action

There has been significant operational and capacity impact, which is well reported in the media, this has resulted in over 35 days of industrial action since December 2022 and the situation currently has no resolution. The impact in the EPRR team has meant a number of objectives haven't been delivered due to prioritisation of this activity, The same occurred during the pandemic and this has been acknowledged both locally and nationally.

The priority has been to maintain patient safety, and the team has been instrumental in putting the frameworks in place with clinical and medical management support to ensure that when industrial action is taking place the Trust can respond to clinical need with less than optimal cover, no significant incidents have presented during industrial action, and the Trust has fully complied with all information requests, both locally and nationally to inform the government on any operational impacts.

NHS England undertakes an annual assurance process against a set of core standards for Emergency Preparedness, Resilience and Response (EPRR). For 2022 / 23 assessment, there has been a significant shift in the assurance process, with an evidence submission required into an on-line portal, for a number of years this has been a self-assessment or peer to peer assessment.

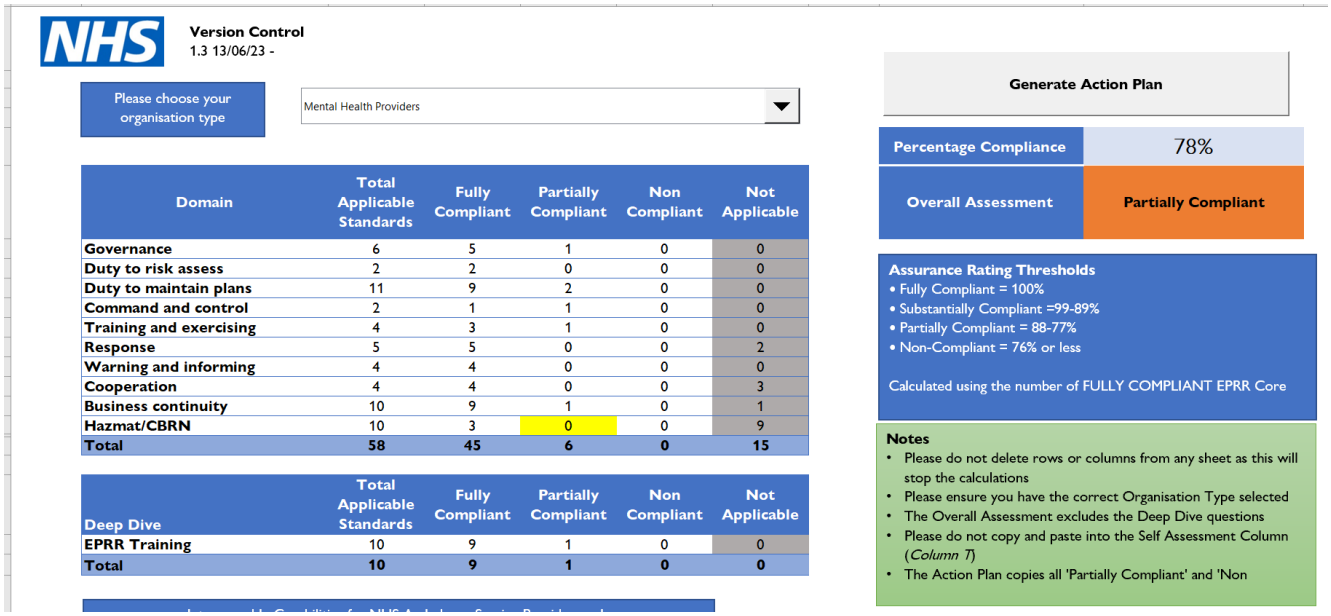
The final assessment was submitted on time on the 29th September, and we await our final assessment results. At the stage we have reported partial compliance.

It is a requirement of the assurance process that the statement of compliance is reported to the Board of Directors / Governing Body Meeting. These standards have been assessed and results are presented as part of this report.

There are 68 core standards questions which apply to Mental Health care providers, our assessment indicates that we are partially compliant with a score of 78%. We have received written notification which has been shared with the Chief Operating Officer (Accountable Executive Officer) that it is an expectation that full compliance will be harder to achieve going forward with a greater level of scrutiny applied to these standards, the EPRR team has completed this assessment only where full evidence can be guaranteed. It is also worthy to note that a full action plan has been created, which will be managed and overseen by the Trust's Emergency Planning Group. Some of these actions are in train in relation to training with national completion timescales set at December 2023, so was to be expected that not all actions would be complete when this assessment was submitted in September 2023.

The main areas of action relate to the following standards:

- Governance – Appropriate resource to fulfil the EPRR agenda for the Trust.
- Collaborative Planning – in relation to plans to deal with a major incident, and psychosocial support.
- Evacuation and Shelter – in relation to awaiting guidance from NHS in relation to secure services
- Trained on-call staff – in relation to all on-call Directors / Associate Directors attending the PHC training dates that have been set.
- EPRR Training – related to action above.
- Business Continuity Plans – not all plans for all suppliers in place – business continuity internal audit about to start and will support this action.
- Hazard Material and Chemical, Biological , Radioactive and Nuclear (CBRN) – a number of standards newly added to Mental health providers assessment, and we are querying the applicability given we are a low risk service for this type of incident.



NHS

Version Control
1.3 13/06/23 -

Please choose your organisation type

Mental Health Providers

Generate Action Plan

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	9	2	0	0
Command and control	2	1	1	0	0
Training and exercising	4	3	1	0	0
Response	5	5	0	0	2
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	9	1	0	1
Hazmat/CBRN	10	3	0	0	9
Total	58	45	6	0	15

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	9	1	0	0
Total	10	9	1	0	0

Percentage Compliance	78%
Overall Assessment	Partially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non

Link to standards here

There are no significant risks relating to this, however available resources and industrial action may impact on the completion of the action plan.

5. RECOMMENDATION / SUMMARY

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

This paper is received for information, and for assurance in relation to the compliance to the EPRR Core Standards submission, and the subsequent action plan created that will be completed throughout 2023 / 24.

Tony Gray
Associate Director of Safety, Security and Resilience

Ramona Duguid
Chief Operating Officer

10th October 2023

Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

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

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

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

Organisational ratin	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

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

Ramona Duiguid

Signed by the organisation's Accountable Emergency Officer

25/10/2023	01/11/2023	01/11/2023	10/10/2023
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report	Date signed

10. SAFER CARE REPORT

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

REFERENCES

Only PDFs are attached

10. Safer Care Report Q2.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**Safer Care Report – Quarter 2 23/24**
Executive Lead	**Dr Rajesh Nadkarni, Executive Medical Director / Deputy CEO** **Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance**
Report author	**Claire Thomas, Deputy Director, Safer Care** **Anthony Deery, Deputy Chief Nurse** **Peter Astbury, Associate Director, Safer Care**

Purpose of the report	
To note	
For assurance	**X**
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

Meetings where this item has been considered	
Quality and Performance	X
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
People	
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Working together with service users and carers we will provide excellent care. Supporting people on their personal journey to wellbeing. 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). SA3.2 Working with Partners there will be “No health without mental health” and services will be joined up. Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of mental health and disability services (SA3.2). SA4 The Trust’s Mental Health and Disability services will be sustainable and deliver real value to the people who use them. 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).

Board of Directors

Wednesday 1st November 2023

Safer Care Report – Quarter 2 2023/24

1. Executive Summary

This is the Safer Care report for Quarter 2 2023/24. This report focusses on key metrics (such as those which are reported outside of the Trust) and now uses Statistical Process Control (SPC) charts which enable better data analysis and identification of areas that require further investigation or review. The narrative provides an analysis of the data while the 'key points' provides additional areas of note and assurance.

Please note data is correct at the time of reporting but is subject to change.

2. Risks and mitigations associated with the report

None to note by exception.

3. Recommendation/summary

Receive the paper for information only.

Name of author:

Claire Thomas, Deputy Director, Safer Care

Anthony Deery, Deputy Chief Nurse

Peter Astbury, Associate Director, Safer Care

Name of Executive Lead:

Dr Rajesh Nadkarni, Executive Medical Director

Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance

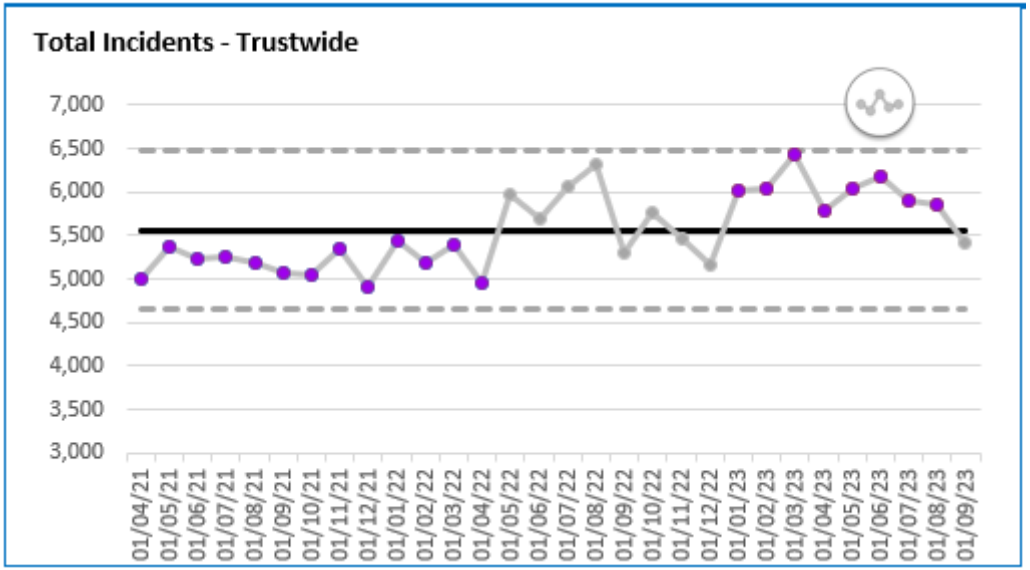
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Safer Care Quarterly Report

October 2023

Reporting Period: July - September 2023

Section 1: Incidents



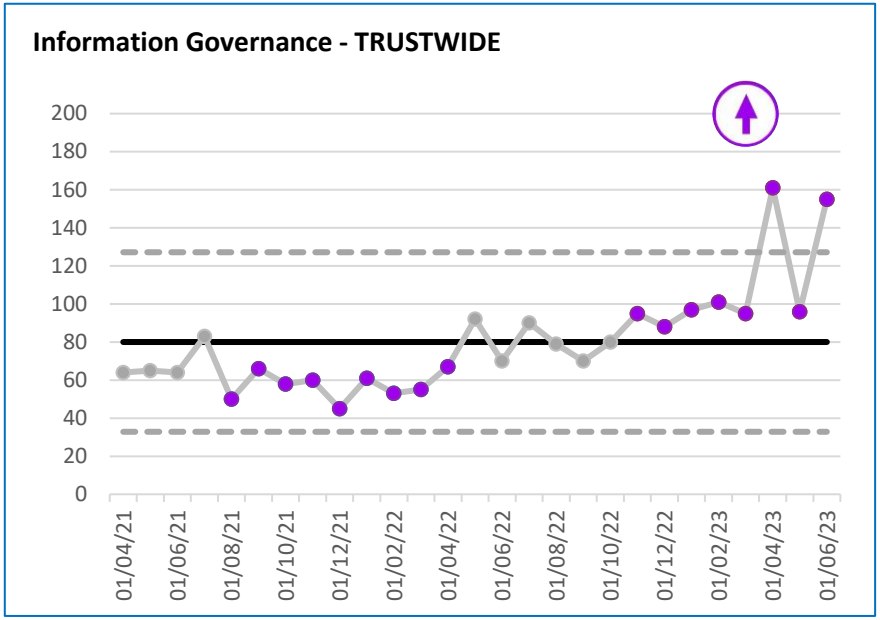
	Jul Variation	Aug Variation	Sept Variation	Q2 Output
Trust wide	↗	↗	~	17,196
North	~	~	~	4,639
Central	↗	↗	↗	3,844
South	~	↗	↗	4,401
North Cumbria	↗	~	↗	3,898

- Total Trust wide reported incidents are showing as within common variation at the end of Quarter 2. This is because despite the months of July and August having higher than average total numbers, the total number of incidents in September dropped to a below average number for the first time since January 2023.

- Locality level incidents were at common variation for North. South continues to flag as special cause high at the end of this quarter with South Access having had a higher than average number of incidents since January 2023, and Inpatients South having been consistently higher than average since May 2022. Throughout this quarter Central has flagged as special cause high consistently linked to higher-than-average numbers in Central Access. North Cumbria has flagged as a high concern in June and September. This correlates with Community and Access services in this locality maintaining high numbers of incidents since the start of 2023.

- Throughout this quarter Trustwide cause groups of Information Governance and Security remain flagged as special cause, both being more than average for the last 11 months. Since the spike in Aggression and Violence incidents in June, the incident numbers have returned to within common variation for Q2.

The Information Governance team continue to see a higher than average number of incidents reported in this quarter, although it should be noted the number of incidents is beginning to decline in comparison to the previous quarter.



The increase in the number of incidents reported relate to a number of factors for example:

- An increase in the number of documents/letters being identified as misfiles in historic paper format records as they progress through the Records Digitisation Quality Check project.
- An increase in the number of Disclosed in Error (Person Identifiable) incidents, which relate to documentation being sent to the incorrect GP. Staff have been advised to ensure GP information on RiO is correct prior to sending however where this is not completed staff are required to report these incidents. This therefore does not necessarily indicate that more mistakes being made, but that more people are reporting them.
- A technical issue identified within the Enhanced Audit function caused a delay in identifying potential inappropriate access to patient Records, in turn this resulted in an increase in the number of Unauthorised Access to Data (Person identifiable) incidents reported. The issue has since been resolved and this peek in reporting should see a reduction in the next quarter.
- As a result of routine regular messaging relating to accessing records there has been an increase in staff self-declarations when they accidentally access an incorrect record.

The IG Team remain committed to providing advice, support and education to staff across the Trust. In the coming months the team will be running an IG campaign and will be represented at the Trustwide managers meeting to address IG incidents.

Patient Safety Incident Framework – PSIRF

CNTW continues to work towards implementation of the new Patient Safety Incident Response Framework (PSIRF). CNTW, as an NHS Provider, are required to have an agreed PSIRF policy and PSIRP (Patient safety incident response plan) in place by Autum 2023.

The PSIRF Core group, continues to meet regularly to discuss PSIRF planning and implementation. The 5 PSIRF workstreams (detailed below) have continued to meet during Quarter 2 and work through their assigned actions.

1. Engaging those affected (Patients, Families, staff)
2. Responding to incidents
3. Learning and Quality Improvement
4. Understanding our Patient Safety Data (PSIRP)
5. Oversight of PSIRF

Workstream outputs have contributed to several key events that took place in September.

- September 11th – Workshop with Workstream Lead's PSIRF core group and Trustwide Safety to review Workstream 2 and 4 outputs and discuss CNTW safety priories and response methods.

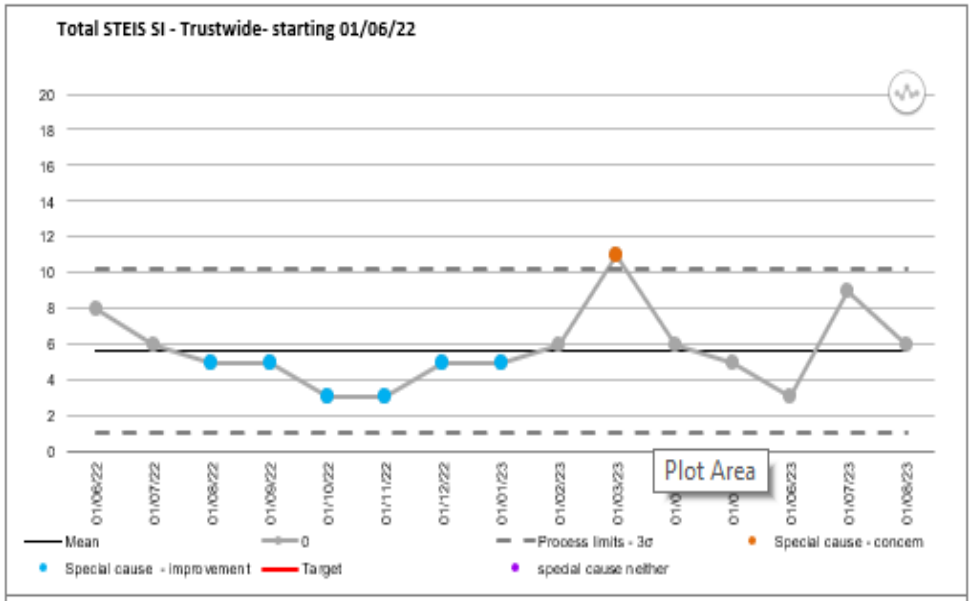
- September 25th – Presentation of work to date was discussed at EMG.

- September 29th – Workstream 1 presented its work focussed on the compassionate engagement of all those affected by Patient safety incidents to the Trustwide Leadership Forum (TLF). These presentations also featured input from Workforce around implementing and embedding an organisational Just Culture.

The outputs of the workstreams to date and the input of all those involved in the event held in September have allowed CNTW to compile its PSIRF policy and PSIRP which were discussed at TSG October prior to Borad presentation and sign off on November 3rd.

As Quater 3 progresses and following board sign off CNTW's preparation for implementation will gather speed as the Trust plans to roll out PSIRF in early 2024.

Section 2: Serious Incidents and Deaths



Locality	Variation Jul	Variation Aug	Variation Sept	Total Q2
Trustwide STEIS Reportable Incidents				18
North Locality				4
Central Locality				4
South Locality				6
North Cumbria Locality				4

This section now only includes STEIS reportable serious incidents (previously included serious incidents not meeting threshold for STEIS but deemed to require a level of formal review).

Please note serious incident numbers are correct at the time of reporting but are subject to change following any review subsequent to reports being released.

- Overall STEIS reportable incidents during quarter 2 were in line with common variation in reported incidents and no concerns flagged relating to the frequency
- Sixteen of the eighteen STEIS reported incidents had the cause group death, with fifteen of those sixteen being unexpected deaths and one alleged homicide by patient.
- One of the STEIS reported incidents pertained to significant self harm which occurred in the community and the other related to a patient accident on an inpatient ward. No concerns flagged relating to frequency.

Reviews of Deaths	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24
Deaths Reported into the LeDeR process	22	13	16	22	15
Complex Case Panel – No. Cases Heard	4	0	0	2	5
Prevention of Future Death Reports Received (Regulation 28)	0	0	1	2	0
Full StEIS Reportable Deaths	12	9	16	17	16
LAAR's	42	58	46	66	33
Non StEIS Reportable Serious Incidents	1	5	1	0	0
72 Hour Reports	20	20	32	43	33
Mortality Review	33	19	38	21	26

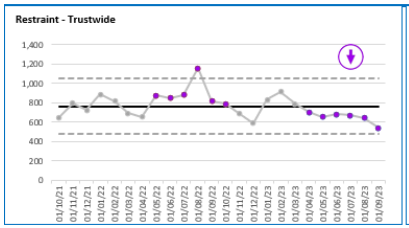
The above incidents are deaths that have been formally reviewed in line with CNTW review levels. The total does not reflect the numbers of Serious Incidents (SI's) as per the NHS Serious Incident Framework definition of an SI. That definition is only applicable to the Full StEIS reportable Serious Incidents.

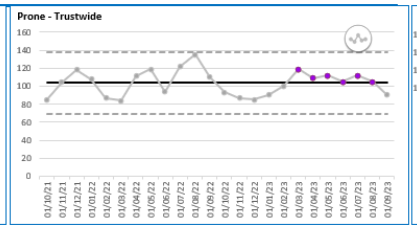
Regulation 28 reports:

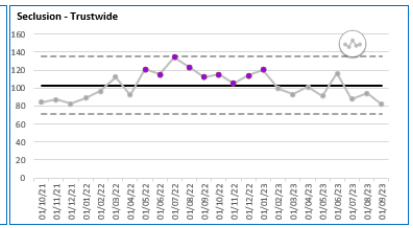
Regulation 28's are issued by Coroners who have a concern(s) that if not addressed could potentially lead to a similar incident reoccurring in future. From the date of issue, the recipient must respond to the Coroner within 56 days outlining what action has been taken to address the concern(s).

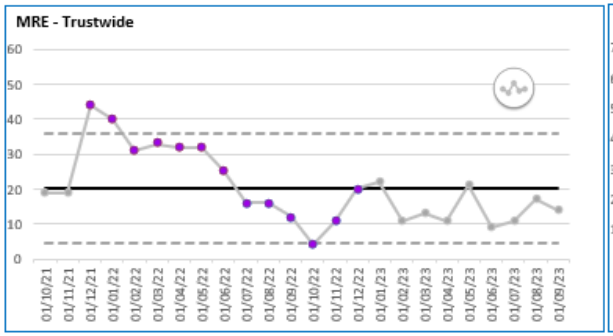
CNTW has received 0 Regulation 28 reports in this Quarter.

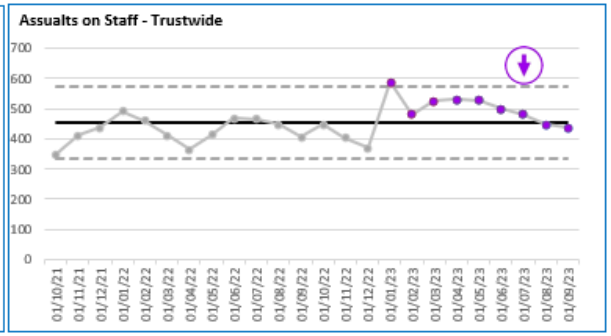
Section 3: Positive and Safe











This quarter the reported incidents for assaults on staff and restraint have flagged to highlight reductions in reported activity. For restraint this is six months below the mean. There is also a continued trend of a reduction below the mean of MRE use and seclusion incidents.

Section 4: Long Term Seclusion

	Jul 23	Aug 23	Sept 23
Long Term Segregation	5	5	5 of which 2 ended in month
Prolonged Seclusion	6	12 of which 5 ended in month	16 of which 12 ended in month

**Data on e-seclusion records on RiO. Only those episodes of prolonged seclusion as of 08:00 every Friday morning are included in the figures.*

Patients in Long Term Segregation

CYPS – Ferndene 1st July

- 3 cases (one commenced Nov 21, two Mar23). As of 30th Sept, only 1 case remains in LTS and a plan is in place to end this in the next quarter.

LD&A - Mitford

- 2 cases (one commenced Aug 18, one Sept 22) – both patients remain in LTS, HOPES support provided including a National HOPES Advisor input for one patient.

Patients in Prolonged Seclusion (1st Jul – 30th Sept)

- CYPS - Alnwood – 1 seclusion in LTS area continues (LTS commenced 2018 and seclusion commenced January 2023)
- LDA - Rose Lodge – 1 seclusion in LTS area continues (LTS commenced 2022 and seclusion commenced February 2023)

Key Points for LTS / PS:

- During Q2 cases were reviewed by the LTS & PS Panel. This included a further review of all Independent Clinical Treatment Reviews (ICTRs).
- Each LTS case is actively supported with internal HOPE(S), this involves training, completion of a Barriers to Change Checklist, development of intervention targets, supervision and practice leadership.
- National HOPE(S) Team supporting cases at Mitford and Alnwood.
- Patient in prolonged seclusion at Alnwood is now over the age of 18 and awaiting placement in an age-appropriate service. The plan is for the patient to move to the new Sycamore Unit in October.
- Supervision/ reflective practice support to teams on an ongoing basis.
- Practice sharing group/peer support for HOPE(S) trainers in place.
- Database of LTS cases and support provided including intervention targets.
- Review of prolonged seclusions or frequent seclusion users on a monthly basis.
- CNTW HOPE(S) lead will review case and offer support to teams.

Training

Training Type	Nationally July 23	CNTW Sept 23
Train the trainer programme – 5-day	75	24
Barriers to Change Checklist - 2-day training	570	105
Awareness training (3 hours)	1205	670

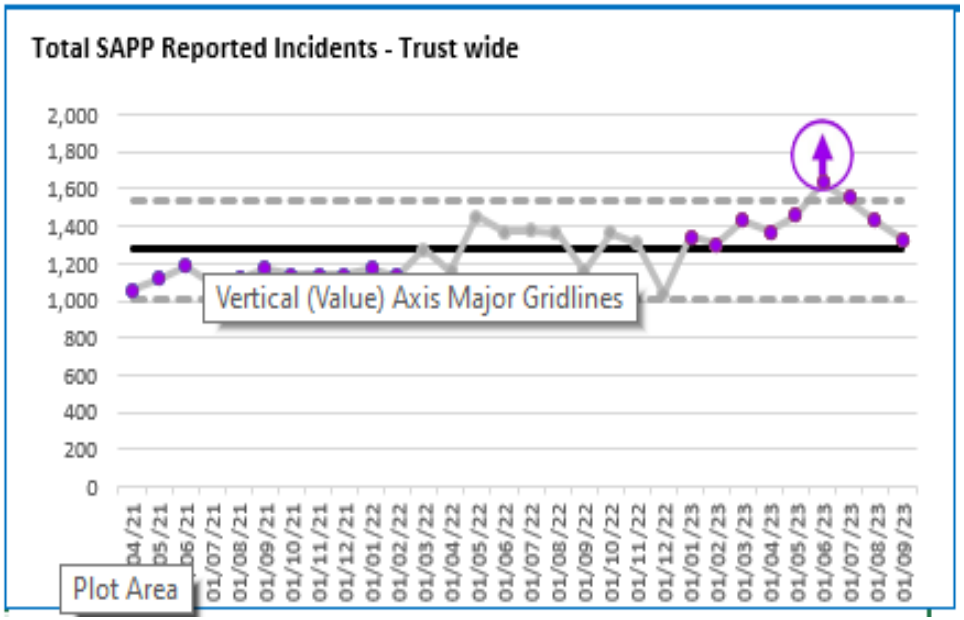
CNTW's completed training in the table above represents a significant proportion of the national figures which is very positive.

Section 5: Safeguarding and Public Protection

Special Cause concern was highlighted throughout every month of this quarter with higher-than-average total Trustwide Safeguarding Incidents being reported.

Locality – Central, North & North Cumbria flagged high every month in the quarter with consistently higher than average numbers. South flagged 6 months of higher-than-average numbers in August, however these figures do remain very close to the mean and have reduced to below average numbers in the month of September.

Increased safeguarding reporting generally is in line with national trends and linked to greater awareness because of the rollout of level 3 training.

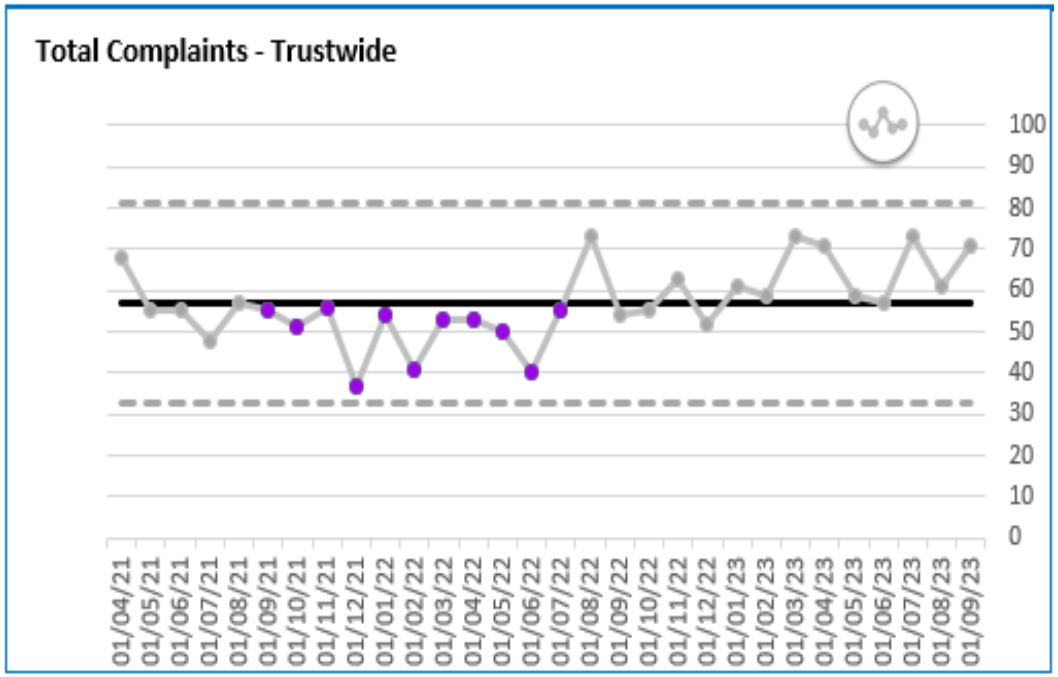


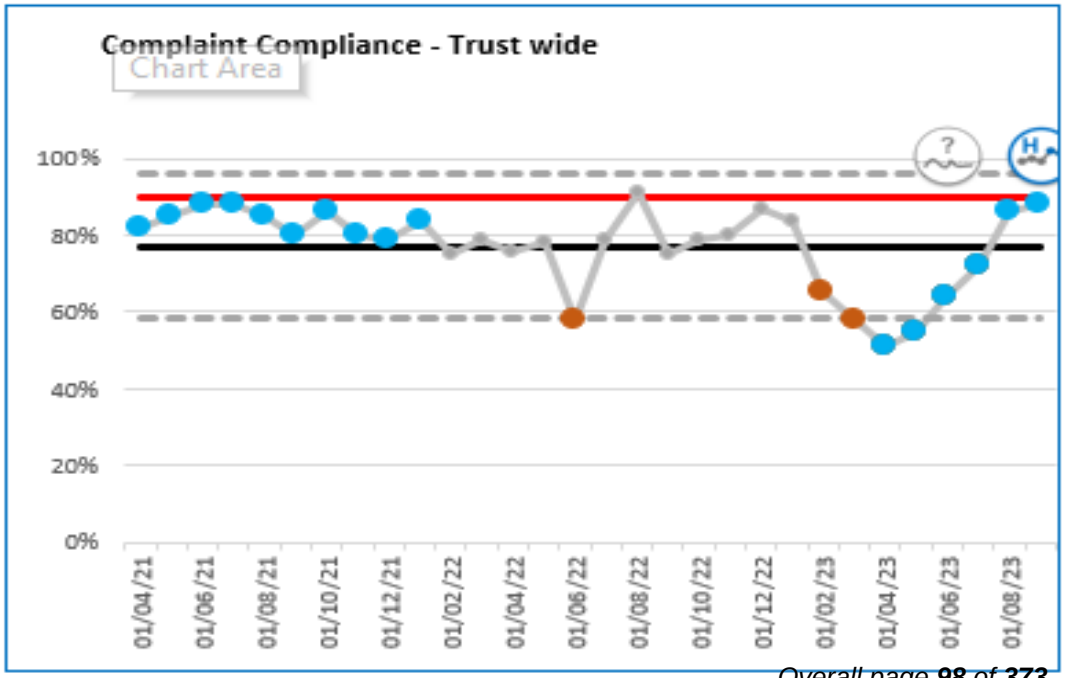
In addition, the expected impact of focussed work of the SAPP team is felt to have increased reporting in some localities.

At 6 months into this financial year safeguarding incidents are the highest single incident cause group at 9205, if this activity level continues to end of financial year it is expected that the total number of Safeguarding incidents reported will be approximately 18,410, a 13% increase from 22/23.

SAPP team continue to have oversight of all reported safeguarding incidents and continue to provide support advice and supervision where required across all clinical localities.

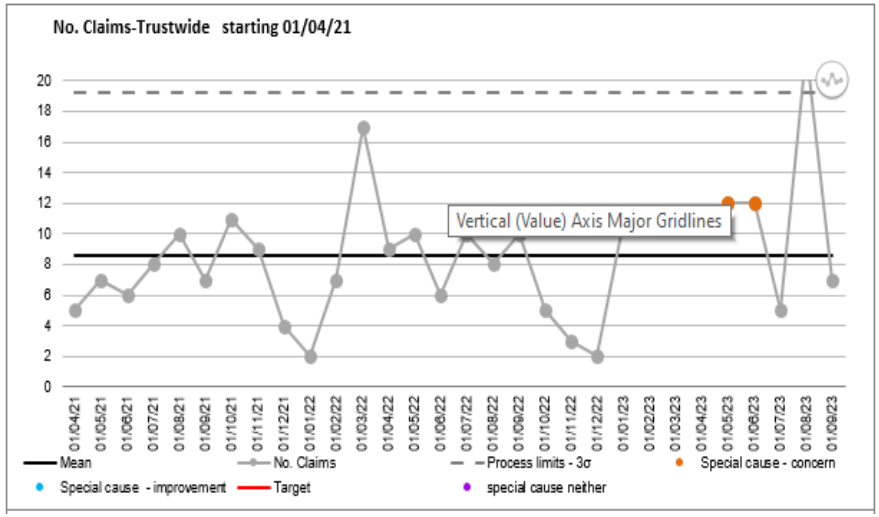
Section 6: Complaints and Claims





At Trust level, total complaints during quarter 2 are showing as in line common variance.

- Average Trustwide complaint compliance was 82.9% in quarter 2 which is a significant improvement on quarter 1.
- There has been a consistent 6 month increase in compliance figures.
- A key factor in the higher compliance rates seen in quarter 2 is that the capacity issues within the complaints team have been addressed with all vacancies now recruited into.
- Localities have been reminded to request extensions in advance of the response date, as once that date has passed an extension cannot be granted and the complaint shows out of time. This lowers the monthly compliance rate.

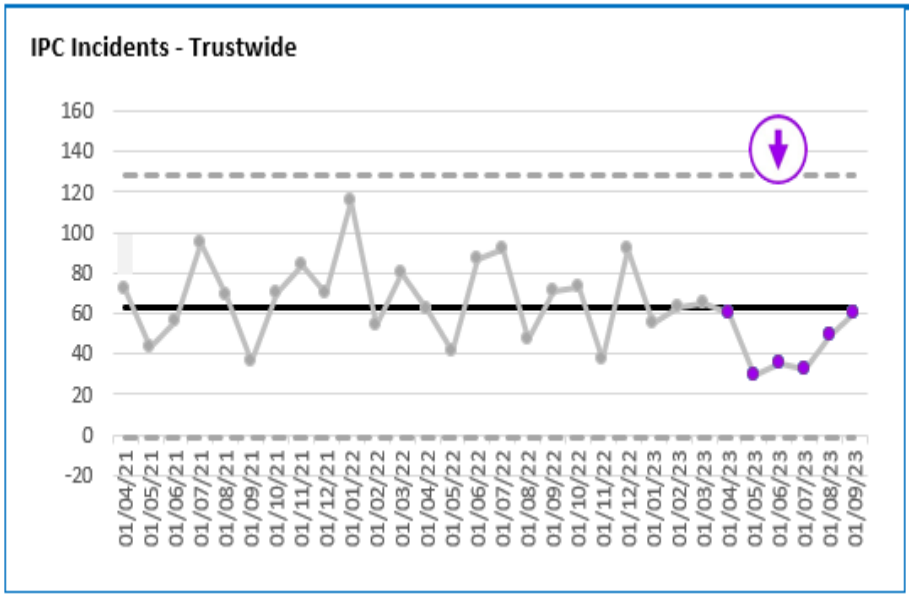


There has been a marked increase in the number of claims received during August 2023. Most of these are ex-gratia claims for missing or damaged patient property. These are widely spread across Trust services; however it is noted three relate to lost patient property on Beckfield Ward and three relate to Fellside Ward, two regarding lost patient property and one from a member of staff for the cost on antibiotics after being bitten by a patient. There has been an increase in clinical negligence claims in Quarter 2 (8 recorded compared to 6 in Quarter 1). For three of these, we have received formal Letters of Claim; two have been logged as potential claims as solicitors have informed us they have been instructed to investigate claims for clinical negligence but no formal Letter of Claim has been received to date. Three are claims made by the Trust for Inquest funding in anticipation of a formal Letter of Claim being received after the Inquest has concluded.

Learning from PHSO investigations

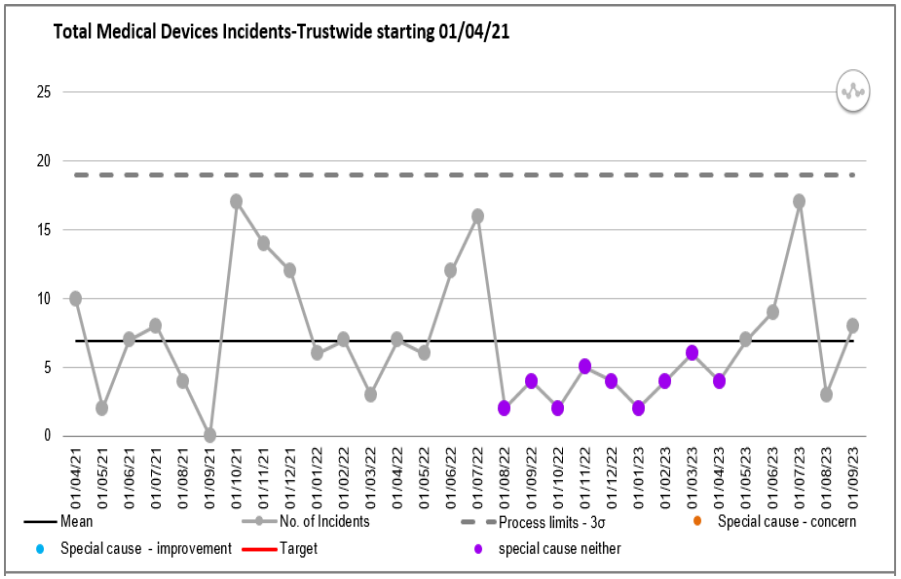
None this quarter

Section 7: IPC and Medical Devices



The number of reported IPC incidents at Trust and Locality level has been in line with common variation during Quarter 2.

- All Safeguard Incident reports continue to be reviewed and follow up by the IPC Team, including all reported infections, Inoculation incidents, sharps /waste issues and environmental issues.
- The triage system continues to work well and there is a prompt and responsive follow up to any queries that come through. For each month of Quarter 2 there was over 100 triage queries sent into the IPC Team.
- July was a quiet period for COVID activity with a noticeable increase in patient cases in August and September.
- During Quarter 2, the IPC Team reviewed and updated IPC PGN 10- Medical Devices & Equipment – Cleaning & Decontamination and this has recently been circulated.
- The IPC Team also contributed to the updated Bowel & Bladder PGN with additional RiO build options. This went live in August.



There was a total of 28 medical devices incidents during quarter 2 of 2023/24. Month on month, these were in line with common variation in the number of reported incidents.

Themes identified in reviewing these incidents include the need for Clinical Teams to identify and proactively source any clinically indicated equipment required prior to their Patients transfer of care or discharge. This needs to be undertaken in a timely manner and with improved communication and collaborative working practice. Clinical staff need to ensure that integrity and functioning checks are undertaken on all clinical Medical Devices prior to their use. This ensures prompt fault reporting and maintenance issues and ensures a quick response to any repairs that are required, as well as ensuring compliance with safe Medical Device

11. CQC MUST DO REPORT UPDATE

Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance

REFERENCES

Only PDFs are attached

11. Summary CQC Must Do Action Plans for Board.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1 November 2023**
Title of report	**CQC Must Do Action Plan Quarter 2 Update**
Executive Lead	**Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance**
Report author	**Vicky Wilkie, CQC Compliance and Governance Manager**

Purpose of the report	
To note	
For assurance	**X**
For discussion	
For decision	**X**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

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

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	X
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	
CQC Inspection Steering Group	X
CQC Quality Compliance Group	X

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Quality care, every day – We want to deliver expert, compassionate, person-led care to every team, every day. 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 (SA1).

Update on CQC Must Do Action Plans

Board of Directors

Wednesday 1st November 2023

1. Executive Summary

This report provides an update on the 17 remaining areas of improvement (Must Do action plans) which were received following inspections undertaken between 2018 and 2022, including the most recent inspection to three adult acute admission wards on the Campus for Ageing and Vitality hospital site in Newcastle.

- This report seeks approval from the Board that there is sufficient evidence and assurance to close 3 action plans linked to staffing and environmental concerns following the transfer of service users to Sycamore Unit at Northgate Park (see Appendix 1).

- Through this report the Board are asked to extend further the action plans relating to restrictive practices, clinical supervision, training, environments and physical health / rapid tranquilisation as further improvements are required.

- Appendix 2 provides an update on the work that continues to address each of the remaining action plans. The revised timeframes will be kept under review and every effort made to shorten these where possible.

- Monthly updates on areas for improvement from previous inspection activity (including CPFT and NTW) are provided to the Executive Management Group and Board of Directors. Below is a breakdown of those that remain open and those that have been closed:

	Must Dos		
	Open	Closed	Total
NTW	1	2	3
CPFT	9	28	37
CNTW CYPS 2020	1	0	1
CNTW LD 2020	0	5	5
CNTW LD 2022	4	4	8
CAV 2022	2	1	3
Total:	**17**	**40**	**57**

- Quarterly updates on all action plans, including the monitoring of previous actions which have been closed (see appendix 3) will continue to be reported to Quality and Performance Committee and Board of Directors.

2. Risks and mitigations associated with the report

The Care Quality Commission has raised all 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 is 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.

Board members are asked to:

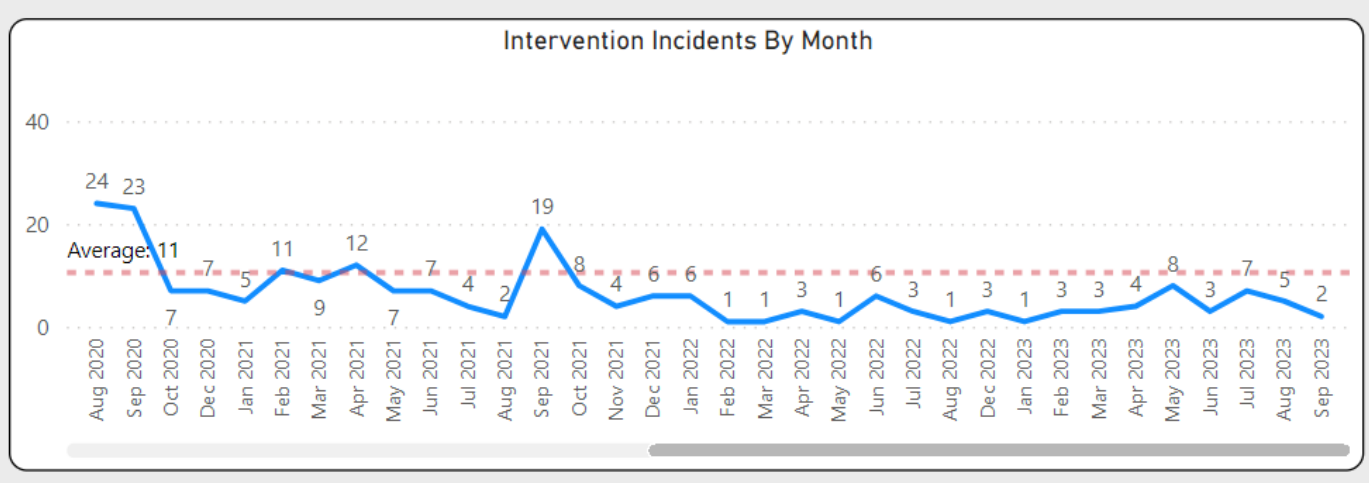
- Approve the closure of 3 action plans listed within appendix 1.
- Approve the date extensions for the action plans related to restrictive interventions, clinical supervision, training, environments and physical health / rapid tranquilisation.
- Note the updates on all 57 CQC Must Do action plans within (including impact changes for those closed).

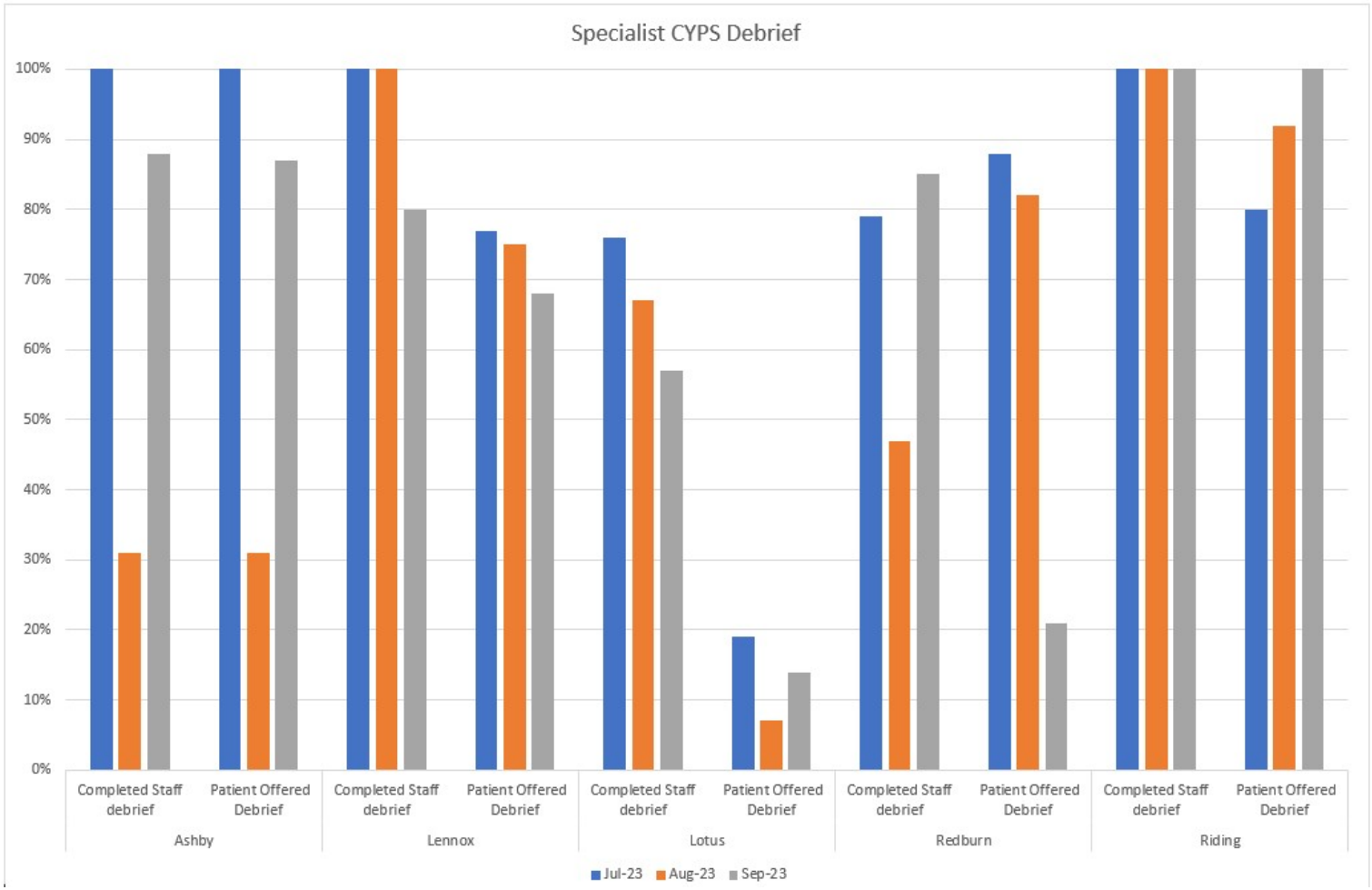
Author:
Vicky Wilkie, CQC Compliance and Governance Manager

Executive Lead:
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance

19th October 2023

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	**Core service, year and organisation**	**Must do**	**Evidence of Impact**
Regulation 10 Dignity and respect	LDA wards Year: 2022 Org: CNTW	People in seclusion on Lindisfarne ward did not have privacy and dignity because staff who were not providing direct care entered the seclusion area regularly.	Complete. Service users have transferred to Sycamore Unit at Northgate Park.
Regulation 12 Safe Care and Treatment	LDA wards Year: 2022 Org: CNTW	There was no nurse call alarm system on Cheviot, Lindisfarne, Tyne or Tweed wards. [This must do is linked to the must do relating to prone restraint].	Complete. Nurse call systems installed across Learning Disability and Autism wards and service users have transferred to Sycamore Unit at Northgate Park.
Regulation 18 Staffing	LDA wards Year: 2022 Org: CNTW	Cheviot ward did not have enough staff on shifts to meet the staffing requirements for enhanced observations. [This must do is linked to the must do relating to LD&A training].	Complete. Service users have transferred to Sycamore Unit at Northgate Park and staff have been identified for allocation to Alwinton (Cheviot, Lindisfarne equivalent in new MSU).

Must Do Theme: (3) Restrictive practices, seclusion and long term segregation		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 September 2023 (30 December 2023)**		**Status:** **Further action required to make improvements**
Must Do:	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.
What the report identified at the time, including what the level of performance was at the time of inspection.	High use of MRE and low compliance with staff and patient incident debriefs.	
What is performance today?	MRE use since the inspection  	

	Debrief compliance during Quarter 2: 
Improvements during 2020 – 2023	• Teams have worked with the HOPEs team to support positive change. • Weekly monitoring of MRE incidents commenced and reported directly to Directors. • MRE debriefs being completed with Director present.

	• Monthly debrief meetings take place with sessions also being completed to focus on the barriers which maybe impacting on completion of debriefs. • Debrief training has been rolled out to staff to help the teams to understand the importance of these being completed. • Weekly monitoring of compliance which is directly reported to the Directors.
Actions taken during Quarter 2	• All wards using an end of day debrief form which will capture the smaller incidents, more significant incidents such as PMVA / MRE / Seclusion / assaults and will be picked up by the staff member allocated on the de-brief rota. Team files with documentation and the rota set up. • Changes were made to the incident reporting form with a prompt added for reporters to capture debrief information at the time of reporting. • Use of force workshop planned for 16 August 2023.
Actions to be taken forward during Quarter 3	• Action plan agreed following Use of force workshop on what changes / updates are required in order for the CYPS wards to stop using MRE by end of March 2024. This is supported by BDG-Quality and Performance. • Agree separate monitoring process for MRE debrief to ensure Director attends as per policy. • Weekly debrief data collated for all other incidents (see compliance above).
Assurance mechanisms	• Improvement in compliance has been seen in relation to MRE use. • Agreement at Board for Trust approach to RRI/MRE planned for November 2023. • Outline plan and timeline to be shared with CQC.

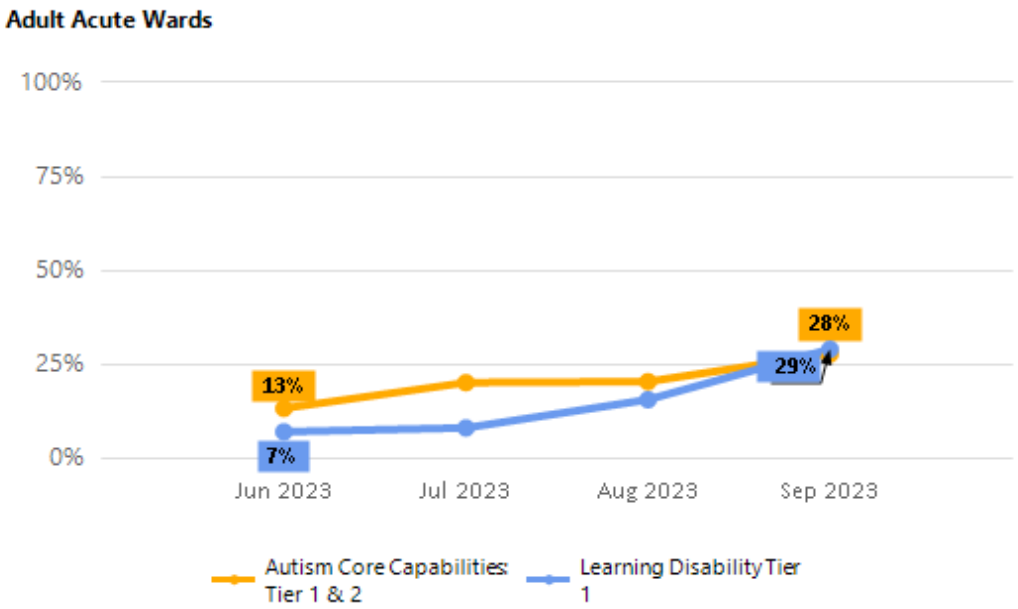
Must Do Theme: (4) Appraisal and Training		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 September 2023 (30 December 2023)**		**Status:** **Further action required to make improvements**
Must Do:	Community CYPS Year: 2018 Org: CPFT	The trust must ensure that staff complete the mandatory training courses relevant to this service in line with trust policy to meet the trusts training compliance targets.
What the report identified at the time, including what the	The compliance for attendance at mandatory training course was 72% overall. Of the mandatory training courses listed, 12 failed to achieve the trust target.	

level of performance was at the time of inspection.	On transfer: The North Cumbria Locality to ensure there are clear plans in place to monitor arrangements ensuring training is accessible to wards and teams. The CPFT training data was not migrated across to CNTW so compliance for the locality started at 0% on 1st October 2019.
What is performance today?	Overall team training compliance is at 77.8%
Actions taken during Quarter 2	Focus on the teams who are not currently achieving the agreed target.
Actions to be taken forward during Quarter 3	• Teams to prioritise immediate and basic life support training, clinical supervision, medicines management and MHA/MCA/DOLS Combined training. • Email will be sent by Group Medical Director to remind medical staff of their responsibilities in completion of mandatory training. • Matrix of the month to focus on areas for improvement. • Training and supervision discussed in locality workforce. • Individual compliance discussed in supervision. • Team meeting have supervision and training as agenda items. • Clinical Manager to produce a highlight report giving narrative and actions on areas that need to be improved. • Managers review dashboards for compliance and discuss in team meetings.
Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (4) Appraisal and Training		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 September 2023 (30 December 2023)**		**Status:** **Further action required to make improvements**
Must Do:	LDA wards Year: 2019 Org: CPFT	The provider must ensure that staff complete their mandatory and statutory training.
What the report identified at the time,	Staff on the ward had not completed their local induction or mental health legislation training. The provider reported that only 57% of staff had completed their local induction and 12.5% had completed their mental	

including what the level of performance was at the time of inspection.	health legislation training. Ten other modules were below the provider's 85% compliance target. On transfer: The North Cumbria Locality to ensure there are clear plans in place to monitor arrangements ensuring training is accessible to wards and teams. The CPFT training data was not migrated across to CNTW so compliance for the locality started at 0% on 1st October 2019.
What is performance today?	15 courses are currently failing to meet the standard (Safeguarding Children level 2 & 3, Clinical Risk and Suicide Prevention, Autism Core Capabilities, Safeguarding Adults level 2 & 3, Medicines Management, Learning Disability Tier 1, PMVA Basic, PMVA Breakaway, MHA/MCA/DOLS Combined, Safeguarding Children level 2 & 3, Seclusion, Resuscitation level 3 (Adult Immediate Life Support).
Actions taken during Quarter 2	Focus on the teams who are not currently achieving the agreed target.
Actions to be taken forward during Quarter 3	• Focused conversation with the Ward Manager and Clinical Manager about these areas. • Weekly reviews now in place with Associate Director and Ward Manager. • Local trajectories have been agreed and a focus on core training standards. • Training and supervision discussed in locality workforce.
Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (4) Appraisal and Training		**Lead:** **Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: **30 December 2023**		**Status:** **Further action required to make improvements**
Must Do:	CAV wards Year: 2022 Org: CNTW	The trust must ensure that the wards have suitably qualified and experienced staff to support all admissions including training in specialist autism and learning disabilities.
What the report identified at the time, including what the level of performance was at the time of	Learning Disability and Autism training compliance was poor.	

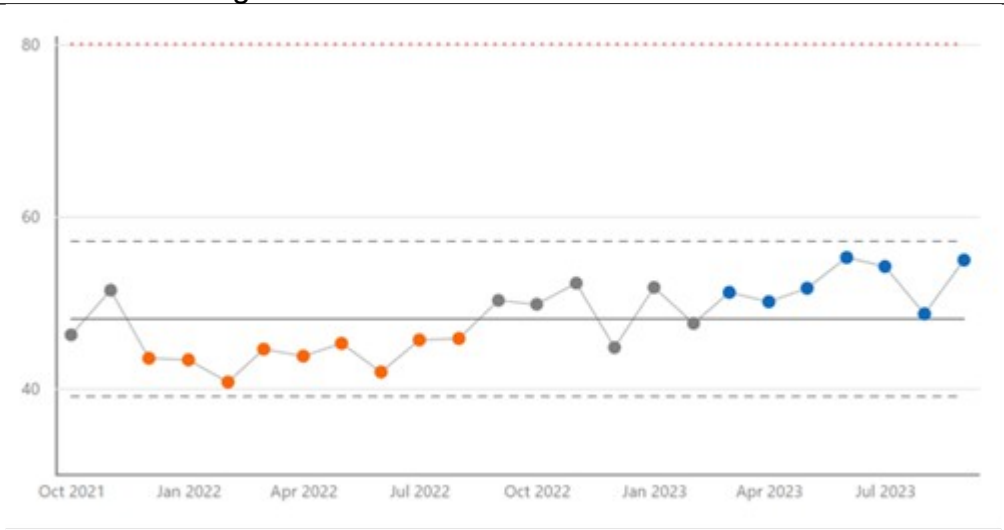
inspection.	
What is performance today?	
Actions taken during Quarter 2	• Promoted Learning Disability and Autism training programme within mainstream Adult Acute wards. • Provided focussed management support in those clinical areas where compliance remains problematic. • Worked with staff agency providers to ensure that there is adequate provision of an acceptable Learning Disability and Autism training package for all agency staff.
Actions to be taken forward during Quarter 3	• Continue to promote training to obtain full compliance (85%) within the designated clinical areas by the end of December 2023. • Continue to regularly monitor at the fortnightly task and finish group as well as Locality management via their local performance and governance oversight.
Assurance mechanisms	• Fortnightly meetings with the Deputy Chief Operating Officer, the respective Associate Directors and reps from training department to review compliance and trajectories • Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (5) Clinical supervision			**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 December 2023**			**Status:** **Further action required to make improvements**
Must Do:	Community OP Year: 2018 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.	
What the report identified at the time, including what the level of performance was at the time of inspection.	Clinical and management supervision was not always taking place in line with trust policy. There was no central monitoring of compliance with the supervision policy. On transfer: Within CPFT staff were either not receiving regular supervision or this was not recorded accurately. The Trust had no clear way to monitor supervision quantity and quality. The commentary and evidence provided is limited to maintain a paper-based system, until the arrival of a more robust system within North Cumbria Locality. Clinical supervision training dates throughout 2020 have been organised. CQC Compliance Officer collates clinical supervision data for all wards and teams. This is collated manually by requesting ward and team managers complete an excel spreadsheet and forward the data to a central mailbox at the end of each month. Over the last 6 months CNTW has been developing an on-line clinical supervision recording system which links to our dashboards – this is still being embedded. Roll out of the system to North Cumbria Locality TBC. North Cumbria using CNTW Supervision Policy.		
What is performance today?	Clinical supervision has improved (68%) but is still below the Trust standard of 85%.		
Actions taken during Quarter 2	New clinical manager in post who will be reviewing current supervision arrangements to ensure staff aligned with supervisor.		
Actions to be taken forward during Quarter 3	• Focused conversation with the Team Manager and Clinical Manager about these areas. • The new Clinical Manager has been leading on the clinical supervision task and finish group. • Clinical supervision is discussed in the locality workforce meeting. • Clinical Manager to produce a highlight report giving narrative and actions on areas that need to be improved. • Managers review dashboards for compliance and discuss in team meetings.		

Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (5) Clinical supervision		**Lead:** **Esther Cohen-Tovee, Director of AHPs & Psychological Services**
Planned timescale for closure: **30 December 2023 (31 March 2024)**		**Status:** **Further action required to make improvements**
Must Do:	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.
What the report identified at the time, including what the level of performance was at the time of inspection.	Staff supervision was not taking place consistently. Not all teams recorded staff supervision figures. The senior management team did not have oversight of staff supervision figures. Supervision figures were not collated centrally. Senior managers were reliant online managers to inform them of any discrepancies. On transfer: Within CPFT staff were either not receiving regular supervision or this was not recorded accurately. The Trust had no clear way to monitor supervision quantity and quality. The commentary and evidence provided is limited to maintain a paper-based system, until the arrival of a more robust system within North Cumbria Locality. Clinical supervision training dates throughout 2020 have been organised. CQC Compliance Officer collates clinical supervision data for all wards and teams. This is collated manually by requesting ward and team managers complete an excel spreadsheet and forward the data to a central mailbox at the end of each month. Over the last 6 months CNTW has been developing an on-line clinical supervision recording system which links to our dashboards – this is still being embedded. Roll out of the system to North Cumbria Locality TBC. North Cumbria using CNTW Supervision Policy.	
Improvements during 2020 – 2023	Significant work to understand barriers and improve adherence to Trust standards has been done during this period: • Ensuring good understanding across all teams of the importance of clinical supervision, the elements of good quality clinical supervision (normative, formative and restorative) and supporting culture change.	

	• Improvements to the Trust's bespoke online recording system for clinical supervision and the addition of a mechanism to record management supervision, which can be done on the same screen if completed on the same date. PGN regarding management supervision has been produced including setting of minimum standard for frequency. • A series of improvements to the Trust Clinical Supervision Policy to increase clarity and support best practice, linked with Trust approach to recording and locality requirements for caseload management supervision as a separate but linked function. • Redesigned training and guidance including video re how to record online that Clinical Supervision has taken place, presentations at Trust managers meetings and 7 minute briefing presented and cascaded. • Revision of guidance regarding safeguarding supervision and integration with mainstream supervision and recording system. • Expansion of Trust-wide Clinical Supervision Oversight Group (CSOG) to ensure all CBUs, professions and Safer Care are represented. The data available to the Chair are reviewed at this monthly meeting and discussed with members who report on the specific improvement work they are doing and challenges. CSOG also has a focus on sharing of good practice, review and improvement of policy and training, communications, and escalation of issues. • CBUs review Clinical supervision data at their Quality Standards meetings, other groups also have regular meetings at which data are reviewed and actions to improve agreed (e.g. fortnightly Clinical Management Team for SALT and Dietetics). • Range of communication strategies have been devised and implemented to update staff regarding any changes and remind them of key points including via the Trust Bulletin, intranet, screen savers and currently developing plans for a short animation • Trust-wide audit and action plan integrated with must do action plan. Audit to be repeated in Quarter 3 this year. • During this period we have seen significant improvement in completion of Trust clinical supervision training and completeness of uptake of clinical supervision in line with the standards we have set. However sustaining improvements in the latter is very challenging as it is easily affected by clinical demands and staff absence / vacancies. The average position of the Trust does not reflect the excellent progress made in many areas. Typically it is inpatient areas with high volume of admissions and acuity that have the most difficulty meeting Trust standards, followed by any team in which sickness or vacancies depletes the supervisory and clinical capacity while clinical demands

	remain high.
What is performance today?	
Actions to be taken forward during Quarter 2	• A number of improvements have been made to the Trust's Clinical Supervision Policy during Quarter 4 last year and Quarter 1 this year, the revised version went through Trust consultation during Quarter 2 and has been approved. • The Deputy Chair of the Clinical Supervision Oversight Group gave an update to Trust Managers regarding these changes and highlighting the forthcoming Trust-wide audit. The Trust-wide training has been updated. • Improvements to the recording system have also been made during Quarter 1 and 2.
Actions to be taken forward during Quarter 3 & 4	Remaining actions for Quarter 3: • Commence Trust-wide audit of adherence to standards and quality of clinical supervision. • Audit closes, analyse results, draft recommendations and review by Clinical Supervision Oversight Group. Quarter 4: • Finalise report and recommendations and present to BDG-Workforce / Trust Quality and Performance Committee. • Any further actions and closure of must do action plan to be agreed.

Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (5) Clinical supervision		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 December 2023**		**Status:** **Further action required to make improvements**
Must Do:	LDA wards Year: 2019 Org: CPFT	The provider must ensure that all staff receive regular supervision.
What the report identified at the time, including what the level of performance was at the time of inspection.	Staff did not receive regular supervision. Since August 2018, out of the 24 staff members on the ward, nine had not received any supervision and 14 others had only received supervision between one and three times. On transfer: Within CPFT staff were either not receiving regular supervision or this was not recorded accurately. The Trust had no clear way to monitor supervision quantity and quality. The commentary and evidence provided is limited to maintain a paper-based system, until the arrival of a more robust system within North Cumbria Locality. Clinical supervision training dates throughout 2020 have been organised. CQC Compliance Officer collates clinical supervision data for all wards and teams. This is collated manually by requesting ward and team managers complete an excel spreadsheet and forward the data to a central mailbox at the end of each month. Over the last 6 months CNTW has been developing an on-line clinical supervision recording system which links to our dashboards – this is still being embedded. Roll out of the system to North Cumbria Locality TBC. North Cumbria using CNTW Supervision Policy.	
What is performance today?	Clinical supervision and management supervision is below Trust standard (11% and 13%).	
Actions taken during Quarter 2	• Compliance data to be discussed each month in ops huddle and monitored month on month for improvement. • Figures will be discussed in HR triage monthly. • Clinical Nurse Manager discusses with Ward Managers in monthly supervision.	
Actions to be taken	• Focused conversation with the Ward Manager and Clinical Manager about these areas.	

forward during Quarter 3	• Weekly review with Associate Director and Ward Manager as clinical supervision remains a key focus.
Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (9) Environmental issues		**Lead:** **Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: **30 December 2023 (December 2026)**		**Status:** **Completion of works**
Must Do:	LDA wards Year: 2022 Org: CNTW	There were issues with the environments on some of the wards. [This must do is linked to the must do relating to seclusion rooms].
Actions taken during Quarter 2	• Essential works to be carried out to improve the internal fabric of the building at Mitford Bungalows (redecoration, replacement of fixtures and fittings and flooring). This work is being prioritised for completion throughout September/October 2023. • Business case developed that demonstrates the benefits of an upgrade of Mitford Bungalows which will require capital funding. • Refurbishment of Edenwood and transfer of patients from Acorn ward took place on 27 September 2023.	
Actions to be taken forward during Quarter 3	• Two out of the four bungalows are in the process of being redecorated, with a plan to rotate the patients into the other bungalows to allow completion of works in the two that are currently occupied. The redecoration is due to be completed by 30 November 2023. • The business case regarding further upgrade of Mitford Bungalows was suspended due to the time it would take to be considered and lack of capital against competing priorities. Therefore a 'phased approach' has been agreed to the work beginning with essential over 3 – 5 years to achieve the desirable.	
Assurance mechanisms	Quality Standards meetings	

Must Do Theme: (9) Environmental issues	**Lead:**

			Dennis Davison, Associate Director
Planned timescale for closure: **30 September 2023 (30 December 2023)**			**Status:** **Completion of works**
Must Do:	LDA wards Year: 2022 Org: CNTW	Three seclusion rooms did not meet the requirements which meant they were not fit for purpose. [This must do is linked to the must do relating to environments].	
Actions taken during Quarter 2	• Resolution to be found (IPad option) to address privacy issues on Tweed ward whilst patients are in seclusion. • Opening of Sycamore.		
Actions to be taken forward during Quarter 3	• Resolution for Tweed ward found, additional IPads on order and ward awaiting receipt. • Sycamore Unit opened and patients transferred.		
Assurance mechanisms	Some elements linked to opening of Sycamore		

Must Do Theme: (9) Environmental issues			**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 September 2023 (30 December 2023)**			**Status:** **Completion of works**
Must Do:	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.	
Actions taken forward Quarter 2	Completion of works on Hadrian 1 and Yewdale courtyard.		
Actions to be taken forward during Quarter 3	• Business case prepared for both bed expansion and continued refurbishment of Hadrian - discussed at Executive Directors. • Recent Estates Strategy meeting to aid formulating wider plan around continued estates developments in Cumbria. • Yewdale issues re-escalated to North Cumbria Integrated Care NHS Foundation Trust.		
Assurance	Quality Standards meetings		

mechanisms	

Must Do Theme: (9) Environmental issues		**Lead:** **Anna English, Group Director**
Planned timescale for closure: **30 July 2024 (30 September 2024)**		**Status:** **Completion of works**
Must Do:	CAV wards Year: 2022 Org: CNTW	The trust must ensure that the premises are fit for purpose.
Actions taken during Quarter 2	• Retro fit windows at Hadrian is now complete. • Car parking secured to the side of Hadrian so staff no longer need to walk through site. • Redecoration of wards completed during August and September. • Transfer of patients from Hadrian to Bamburgh Clinic at St Nicholas Hospital has been delayed until September 2024.	
Actions to be taken forward during Quarter 3	Completion of transfer now scheduled for September 2024.	
Assurance mechanisms	Quality Standards meetings	

Must Do Theme: (12) Physical health and Rapid tranquilisation		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 September 2023 (30 March 2024)**		**Status:** **Further action required to make improvements.**
Must Do:	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	The trust must ensure staff monitor patients' physical health including, following rapid

	wards Year: 2019 Org: CPFT	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]
	LDA 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.
What the report identified at the time, including what the level of performance was at the time of inspection.	In acute wards for adults of working age and psychiatric intensive care units, staff were not always monitoring the physical health of patients after rapid tranquilisation. Review 'The Management of Rapid Tranquillisation' Policy (NTW(C) 02) to ensure it reflects contemporary, high quality care delivery and provides accurate and appropriate clarity regarding duties, accountability and responsibilities.	
Improvements during 2020 – 2023	• Trust-wide task and finish group was set up with representatives from all localities. • Trust-wide audit completed to note current performance. • NEWS form has been added to RiO and now recorded electronically. • Checklist was implemented for staff to use to ensure all required areas. • Session held within task and finish group using SEIPS model to identify barriers that were preventing compliance. • Feedback from this session was fed back to the policy owner for Rapid Tranquilisation. • Body maps discussed as part of the Rapid Tranquilisation task and finish group. • Body map has been added to RiO. • Trust-wide audit completed on body maps with changes made to the form to assist in compliance. • Briefing prepared for Clinical Effectiveness Committee / Audit committee to delay next audit pending policy refresh and use / localise POMH – 16c Rapid Tranq scheduled for next year beginning February 2024. • Communication via the Bulletin has been made for both Rapid Tranquilisation and body maps. • Electronic Observations / Rapid Traquilisation stats now being pulled on a monthly basis for discussion	

	at meetings. Discussions about interpretation and how this could be used for monitoring.
What is performance today?	The audit has evidenced little improvement despite ongoing training and communications being provided on the subject.
Actions taken during Quarter 2	• Continued monitoring via localities of the Rapid Tranquillisation monitoring form. • Ongoing rollout of training across localities to ensure compliance increases. • All adult wards now live with the Rapid Tranquilisation NEWS form. This will need continued monitoring to ensure embedded and for any further glitches to worked through by digital / informatics. • PEWS to be added onto RiO. • Rapid Tranquilisation Policy review complete.
Actions to be taken forward during Quarter 3 and 4	• Rapid Tranquilisation Policy reviewed and out for consultation. • Communication exercise with staff with regard to what will be expected in line with policy. • Deferred Rapid Tranquilisation re-audit following policy review. • POMH – 16c Rapid Tranquilisation scheduled for next year beginning February. This can be localised with addition of local questions so we will have audit activity that can check and inform practice.
Assurance mechanisms	Review results of POMH Quarter 4 audit.

CLOSED MUST DOS:

Must Do Theme: (1) Personalisation of care plans	**Lead: Sheree McCartney, Group Nurse Director**	
		Status:
Community LD Year: 2016 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.	Closed by Board of Directors on 3 August 2022.
Community OP Year: 2018 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: 2018 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.	
Trust-wide	The work around personalisation of care planning to continue due to the repeated concerns and internal intelligence received during Quarter 3 & 4.	

Actions taken at Trust-wide level during Quarter 4 & 1:

- Full audit took place at the end of 2022 and the final report and action plans were signed of at Clinical Effectiveness Committee in May 2023 which showed areas of concern remain.
- Devised locality specific action plans which are monitored through Locality Quality Standards meetings following outcome of recent audit.
- Personalised care plan training continued to be rolled out. Each locality has a rolling training programme which is monitored by the locality Operational Support Manager and reported into the monthly Quality Standards meeting.
- Recirculation of posters and materials to be displayed in wards promoting personalised care planning. Assurance provided from Associate Nurse Directors that these are in place and being displayed.
- Article was posted in the Trust Bulletin on 23 May 2023 to promote the recent audit, findings and next steps.
- Agreed Working Group of the Inpatient Quality Framework to set up with a focus around the quality of care plans.

Planned future actions to be taken at Trust-wide level during Quarter 2 & 3 23/24:

- Trust-wide care planning group established as part of the Inpatient Quality Framework Group attended by locality Associated Nurse Directors chaired by Sheree McCartney, Group Nurse Director they met on 16 June 2023. Second meeting to take place in July.
- Identified training needs across all teams, and all members of MDT – ongoing roll out.
- There is some ongoing work with the RiO build to consider a care plan evaluation as part of this.
- The care plan audit tool is to be updated to reflect the training and requirements.
- Additional RiO Sub Group to be stood up to include Mike Jones to look specifically at care planning.

• Associate Nurse Directors to work with Mark Campbell to mock up a RiO care plan, considering what we need, in what place on RiO, and to also consider if we can include care need specific hyperlinks in care plans, to direct staff to specific policies/PGN's. • Consideration to be given as to whether the care coordination documentation / care plan can pull through to the care plan section and impact positively on reporting. • Ongoing roll out of the personalised care planning training this has been added to dashboards so compliance can be monitored, there is currently some data quality issues which are being rectified to ensure all training that has taken place is captured accurately. • Continue to include this as a standing agenda item on locality Quality Standards meetings and locality CQC Compliance meetings.
Evidence of Impact:
• The metric for the number of current service users who have discussed their care plan remains similar to the Quarter 1 position: o North Cumbria Locality – 87% (June), 86% (September) o North Locality – 97% (June), 96% (September) o Central Locality – 95% (June), 96% (September) o South Locality – 93% (June), 93% (September) • MHAR visit feedback.

Must Do Theme: (2) Blanket restrictions		**Lead: Bill Kay, Group Nurse Director**
		Status:
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.	Closed by Board of Directors on 3 November 2021.
Adult Acute wards Year: 2019 Org: CPFT	The trust must ensure that blanket restrictions are all reviewed and individually risk assessed.	
Evidence of Impact:		
• Review of Trust Policy during Quarter 3. • MHAR visit feedback.		

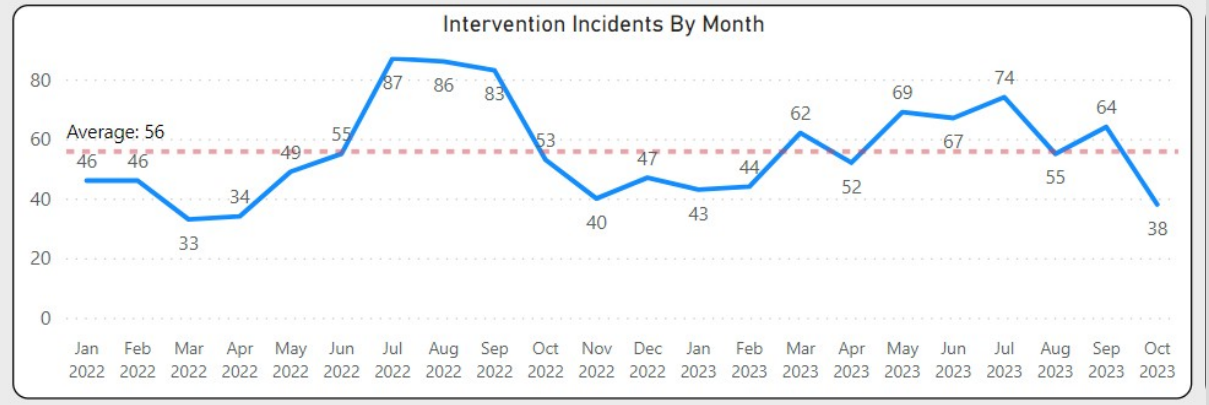
Must Do Theme: (3) Restrictive practices, seclusion and long term segregation	**Lead: Anthony Deery, Deputy Chief Nurse and Locality Group Directors**	
		Status:
LDA wards Year: 2022 Org: CNTW	One person had restrictions in place including long term seclusion and no access to their personal belongings which was not based on current risks. There were no plans to end the restrictions.	Action plan closed as patient transferred to a different hospital on 18 August 2022.
LDA wards Year: 2022 Org: CNTW	There was a high use of prone restraint. [This must do is linked to the must do relating to nurse call systems].	Closed by Board of Directors on 7

		June 2023.
LDA 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 [Linked to rapid tranquilisation task and finish group].	Closed by Board of Directors on 6 September 2023.

Evidence of Impact:

- Safer Care Quarterly Report.
- MHAR visit feedback.

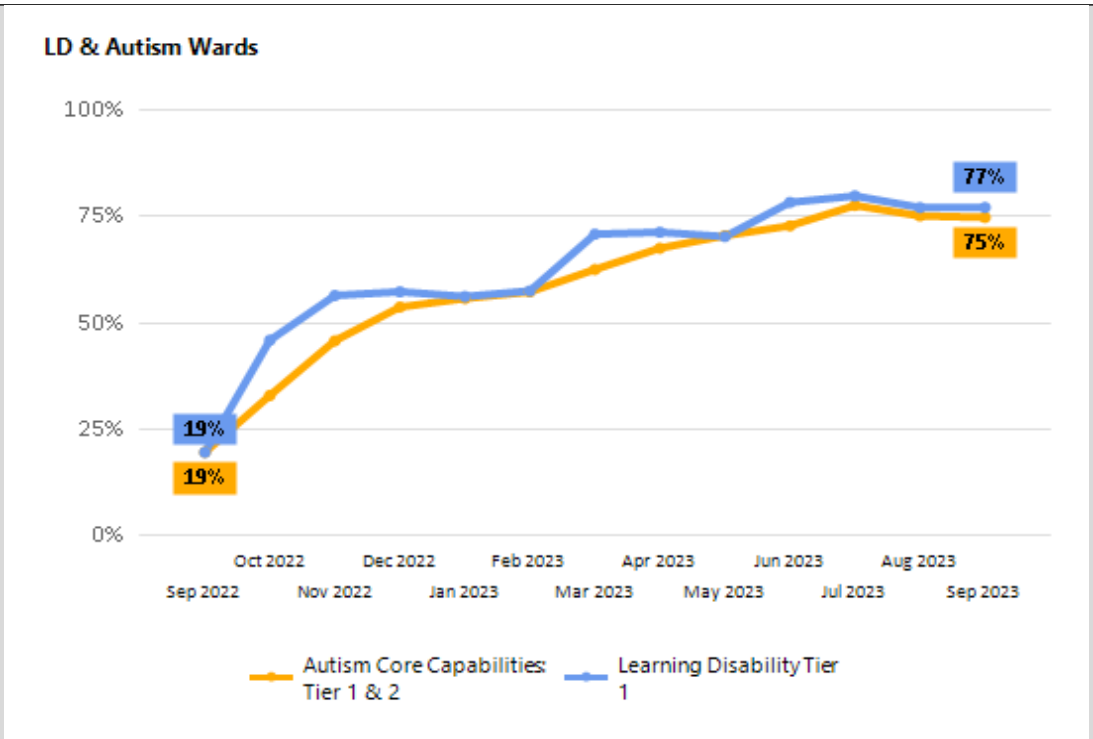
Prone use since the inspection:



Must Do Theme: (4) Training and Appraisals	**Lead: David Muir, Group Director**
	Status
Community LD Year: 2016 Org: CPFT	The trust must ensure that all staff have an annual appraisal.	Closed by Board of Directors on 5 July 2023.
LDA wards Year: 2022 Org: CNTW	Staff did not receive training in learning disabilities or autism. [This must do is linked to the must do relating to Cheviot staffing].	Closed by Board of Directors on 6 September 2023

Evidence of Impact:

- Integrated Performance Report.
- MHAR visit feedback.



Must Do Theme: (6) Risk registers	**Lead: Debbie Henderson, Director of Communications and Corporate Affairs**	
		Status:
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.	Closed by Board of Directors on 5 August 2020.
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.	

Evidence of Impact:

- Cycle of risk register review through Executive Management Team (previously Trust Leadership Team).
- Review and update of Risk Management Strategy received by Board in November 2020. Current review deferred to reflect 2023 strategy and priorities.
- Board Development session in February 2021 to review risks, identify any emerging risks to be added to BAF, review risk appetite categories and scoring.
- Future Strategy, With you in Mind launched May/June 2023.
- Risk Management Strategy and revised Board Assurance Framework to be taken to the November 2023 Board meeting.
- Management meeting framework revised to incorporate risk updates at BDG-Business, BDG-Workforce and BDG-Quality and Performance.

Must Do Theme: (7) Documentation of Consent and Capacity	**Lead: Bruce Owen, Mental Health Legislation Steering Group Chair**
	Status:

Community OP Year: 2018 Org: CPFT	The trust must ensure that consent to treatment and capacity to consent is clearly documented in patient's records.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
• MHAR visit feedback.		

Must Do Theme: (8) Collecting and acting on feedback from service users and carers	**Lead: Allan Fairlamb, Head of Commissioning & Quality Assurance**	
		Status:
Community CYPS Year: 2018 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.	Closed by Board of Directors on 5 August 2020.
Evidence of Impact:		
Quarterly report to Board on patient feedback.		

Must Do Theme: (9) Environmental issues	**Lead: Russell Patton, Deputy Chief Operating Officer, Paul McCabe, Director of Estates and Facilities & Locality Group Directors**	
		Status:
Community OP Year: 2018 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.	Closed by Board of Directors on 26 May 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.	Closed by Board of Directors on 4 August 2021.
Long stay / rehab wards Year: 2016 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.	Closed by Board of Directors on 4 August 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.	Closed by Board of Directors on 3 November 2021.
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.	Closed by Board of Directors on 7 June 2023.
Evidence of Impact:		
Completion of works.		

Must Do Theme: (10) Risk assessment and record management		Lead: David Muir, Group Director
		Status:
Community LD Year: 2016 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.	Closed by Board of Directors on 3 August 2022.
Community CYPS Year: 2018 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.	
CAV wards Year: 2022 Org: CNTW	The trust must ensure that all staff are aware of patients risks and risk management plans on all wards.	Closed by Board of Directors on 6 September 2023.

Evidence of Impact:

- The metric (101) for service users with a risk assessment undertaken/reviewed in the last 12 months remains similar to previous quarters:
  - North Cumbria Locality – 89% (June), 88% (September)
  - North Locality – 98% (June), 98% (September)
  - Central Locality – 97% (June), 98% (September)
  - South Locality – 97% (June), 97% (September)

- The metric (102) for service users with identified risks who have at least a 12 monthly crisis and contingency plan remains similar to previous quarters:
  - North Cumbria Locality – 83% (June), 81% (September)
  - North Locality – 96% (June), 95% (September)
  - Central Locality – 95% (June), 95% (September)
  - South Locality – 94% (June), 95% (September)

- Compliance for clinical risk and suicide prevention training standards at Quarter 2:
  - North Cumbria Locality – 83% (June), 71% (September)
  - North Locality – 84% (June), 79% (September)
  - Central Locality – 85% (June), 81% (September)
  - South Locality – 89% (June), 81% (September)

- MHAR visit feedback.

Must Do Theme: (11) Staffing levels		Themed Lead: Anthony Deery, Deputy Chief Nurse and Locality Group Directors
Planned timescale for closure: 31 March 2023		**Status:**
Community CYPS	The trust must ensure that there are a sufficient number of appropriately skilled staff to enable the	Closed by Board of

Year: 2017 Org: CPFT	service to meet its target times for young people referred to the service.	Directors on 3 August 2022.
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.	Closed by Board of Directors on 3 August 2022.
LDA wards Year: 2019 Org: CPFT	The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.	Closed by Board of Directors on 3 August 2022.
Rose Lodge Year: 2022 Org: CNTW	The service must ensure that the ward has enough suitably trained and qualified staff on each shift.	Closed by Board of Directors on 7 June 2023.
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.	Closed by Board of Directors on 6 September 2023
Evidence of Impact:		
• Vacancy levels. • Safer staffing reports. • MHAR visit feedback.		

Must Do Theme: (13) Governance	**Lead: Debbie Henderson, Director of Communication and Corporate Affairs**	
		Status:
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.	Closed by Board of Directors on 5 August 2020.
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.	Closed by Board of Directors on 4 November 2020.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure they take action in response to regulatory requirements and the findings of external bodies.	Closed by Board of Directors on 7 June 2023.
Evidence of Impact:		
• Trust-wide governance structures. • Agreed terms of reference and policies in place. • 2022 Independent Review of Governance findings and action plan. • Outputs from 2023 Trust-wide Governance review led by Debbie Henderson. • Trust-wide review of the governance framework undertaken February – May 2023 and implemented from June 2023.		

Must Do Theme: (14) Staff engagement	**Lead: Anna Williams, Group Nurse Director**

		Status:
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.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
Staff survey results and local action plans.		

Must Do Theme: (15) Medicines Management	**Lead: Tim Donaldson, Chief Pharmacist/Controlled Drugs Accountable Officer**	
		Status:
LDA 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.	Closed by Board of Directors on 4 August 2021.
Evidence of Impact:		
• Medicines Management Assessments and pre CQC checks. • Review results of POMH Quarter 1 re-audit.		

Must Do Theme: (17) Bed Management	**Lead: Andy Airey, Group Director**	
		Status:
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.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
The number of OAP days have decreased from 1189 (in Quarter 1) to 807 and relates to 32 patients. • Sunderland – 325 (June), 117 (September) • South Tyneside – 155 (June), 119 (September) • Newcastle - 169 (June), 180 (September) • Gateshead – 248 (June), 4 (September) • Northumberland – 62 (June), 80 (September) • North Tyneside – 33 (June), 80 (September) • North Cumbria – 400 (June), 227 (September)		

Must Do Theme: (18) Section 17 Leave	**Lead: Bruce Owen, Mental Health Legislation Steering Group Chair**	
		Status:
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.	Closed by Board of Directors on 4 August 2021.
Evidence of Impact:		
• Compliance with Section 17 leave expiry dates continues to improve. • MHAR visit feedback.		

Must Do Theme: (19) Clinical audits	**Lead: Dr Stuart Beatson, Group Medical**

	Director	
		Status:
LDA wards Year: 2019 Org: CPFT	The provider must ensure that clinical audits are effective in identifying and addressing areas of improvement within the service.	Closed by Board of Directors on 3 February 2021.
Evidence of Impact:		
• Locality and Trust-wide governance structures. • Locality cycle of meetings. • Locality tracker.		

12. QUALITY PRIORITIES (Q2) UPDATE

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

12. Quality Priority Update Q2 2023-24 Board Nov 2023.pdf

Board of Directors
Wednesday 1st November 2023

Title of report	**Quality Priority Update Quarter 2 2023/24**
Report author(s)	**Paul Sams, Feedback and Outcomes Lead**
Executive Lead (if different from above)	**Ramona Duguid, Chief Operating Officer**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	

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

Management Group meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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	x	Service user, carer and stakeholder involvement	

Board of Directors

Wednesday 1st November 2023

Quality Priority Update Quarter 2 2023-24

Executive Summary

As part of preparing the Annual Quality Account, the Trust identified 7 Quality Priorities for 2023-24 which are shown in the table below.

Domain	Quality Priority	What we want to improve this year	Lead	Quarter Position

Safety	Reducing Restrictive Practice	• Reduce the use of restrictive interventions
		• Reduce the use of Prone Restraint
		• Reduce the use of Long Term Segregation
		• Improve training and education of all relevant staff around
		  ○ Trauma Informed Care
		  ○ Human Rights
		  ○ HOPES Clinical Model.
			Anthony Deery	Partially Met

Effectiveness	Therapeutic Engagement and Observation	• Improve training and education for all relevant staff who undertake engagement and observation. • Improve the quality of therapeutic engagement. • Review approach to engagement and observations.	Chloe Mann	Partially Met
Experience	Waiting Times for Children and Young People	• Review and design an improved consistent pathway and staffing model for CYP neurodevelopmental. • Agree with the ICB to undertake a multi agency approach to the significant long waits across the system. • Improve family and carer support and communication. • Reduce long waits for access to services and support.	Andy Airey	Partially Met
Well Led	Implementation of PSIRF	• Implement the new PSIRF in accordance with national timeframes.	Claire Thomas	Met
	Closed Cultures	• Establish a 'live' process to look at early warning triggers across	Ramona Duguid	Partially Met.

		inpatient services. • Increase visibility and leadership visits out of hours and at weekends. • Establish the healthcare assistant development programme. • Review the response to the Edenfield recommendations to ensure they are embedded.		
	Governance Review	• Embed the changes following the organisational governance review.	Debbie Henderson	Partially Met
Use of Resources	Reduce reliance on unregistered agency staff	• Achieve national agency cap standard (£1.2m per month) as a minimum. • Delivery a revised bank staffing system. • Deliver revised inpatient staffing baseline.	Ramona Duguid	Partially Met

The tables below provides more detail about the Quality Priority and its associated milestones and outcomes measures, as well as the position as at quarter end.

Quality Priority 1: Reducing Restrictive Interventions	**Lead: Anthony Deery** **Contributors: Jo Brackley**
• The aim of this Quality Priority is twofold. Primarily it is to ensure patients are cared for in the least restrictive way to avoid any iatrogenic harm and safeguard their human rights. Secondly to support the health and well-being of our staff by supporting them to apply approaches that are less likely to cause harm to them and the patients they care for.	
Milestones during Quarter 1 (April, May & June):	
• Reduce the number of patients in Long Term Segregation or prolonged seclusion. • Train the Trainer – HOPES Model – 24 staff trained	
Milestones during Quarter 2 (July, August & September):	
• Continued roll-out of HOPES Model Training • Reduce the use of Mechanical Restraint Equipment (MRE) • Use of Force Workshop – CYPS CBU – completed 16.8.23	
Milestones during Quarter 3 (October, November & December):	
• Use of Force Act Workshop – Learning Disability and Autism Core Service • Board Development Session – November	
Milestones during Quarter 4 (January, February & March):	
• Implementation of dedicated RRI support team • Implementation of CYPS Use of Force Act Plan.	
Evidence of Impact: For this quarter	
• 2 LTS ended in June and July	

- HOPES Barriers to Change Training – 2-day training (BCC) -105 staff
- HOPES Awareness Training (3 hours course) – 670 staff
- All patients subject to LTS/PS have a completed BCC - complete
- MRE use
    - The incidents of MRE use increased slightly form Q1 (41) to Q2 (43)
    - The level of care for 2 patients, 1 Mitford and 1 CYPS accounted for 25% and 21% respectively of all cases of MRE use. The CYPS patient is Clinically Ready For Discharge (CRFD) and following their transfer from Ferndene to Alnwood there has been a reduction in the number of incidents for this patient.
    - While the majority of MRE incidents occurred in CYPs and LD&A services, the other incidents occurred in, Secure (9 pts), PICU (4pts), Adult Acute (7pts) and Psychiatric Liaison (1pt)

Status: Partially Met

Quality Priority 2: Therapeutic Engagement and Observation	**Lead: Chloe Mann** **Contributors: Group Nurse Directors and Associate Nurse Directors**

Therapeutic engagement and observation are to ensure the sensitive monitoring of the behaviour, mental state and well-being of people receiving inpatient care, enabling a rapid response to any change. This will support preventing inpatients from coming to harm by harming themselves or others.

1. An overarching action plan will be developed to take forward the areas of concern identified within the audit report.

Progress will be reported monthly to each of the Localities Quality Standards meetings.

The overarching action plan will be reported to relevant Trustwide meetings.

2. A root cause analysis will be conducted on significant areas of reduced compliance within each Locality to understand the corrective actions required.

3. An updated online training package has been developed and all clinical staff completing observation and engagement are required to complete the new version of training.

4. An audit tool will be developed to support ward managers to check compliance with the policy. On completion of the audit tool, it will be shared within Locality and CBU Quality Standards meetings for awareness of the process and requirement for completion.

5. Associate Directors and Clinical Nurse Managers will be reminded of the policy in relation to the requirement that Engagement and Observation compliance must be discussed within staff member's supervision.

6. Associate Directors and Clinical Nurse Managers will be reminded that where ongoing issues are identified in relation to a staff member's compliance, the issue must be escalated to the relevant Group Nurse Director.

Milestones during Quarter 1 (April, May & June):

1. Action plan developed and reported to all Locality Quality Standards meetings.

Action plan ratification due at CEC September.

2. Deadline 31.12.23

3. Q1 position:

North 37%
Cumbria 29.1%
South 38.6%
Central 42.1%

4. Development of audit tool.
5. Ongoing monitoring at Locality Quality Standards meeting. Awaiting ratification of action at Clinical Effectiveness committee.
6. Ongoing monitoring at Locality Quality Standards meeting. Awaiting ratification of action at Clinical Effectiveness committee.

Milestones during Quarter 2 (July, August & September):

1. Ongoing monitoring of action plan at Locality Quality Standards meetings.

CEC September was stood down. Ratification of the action plan now due at CEC October.

2. Deadline 31.12.23. Root cause analysis ongoing. Completion by ANDs

3. Q2 position:

North 68%
Cumbria 57.8%
South 69.7%
Central 68%%

4. Audit tool ratified as part of the Engagement and Observation policy.

Policies - Engagement And Observation Policy.pdf - All Documents (sharepoint.com)
Appendix c

5. Ongoing monitoring at Locality Quality Standards meeting. Awaiting ratification of action at Clinical Effectiveness committee.

6. Ongoing monitoring at Locality Quality Standards meeting. Awaiting ratification of action at Clinical Effectiveness committee.

Milestones during Quarter 3 (October, November & December):

1. Ongoing monitoring of action plan at Locality Quality Standards meetings. Ratification of the action plan now at CEC October.

2. Deadline 31.12.23. Root cause analysis ongoing by ANDs

3. Q3 position: all localities to aim for 95% clinical staff compliance

4. Updated Engagement and Observation policy to go to BDG for formal ratification.

5. Ongoing monitoring at Locality Quality Standards meeting following ratification of action plan at Clinical Effectiveness committee.

6. Ongoing monitoring at Locality Quality Standards meeting following ratification of action plan at Clinical Effectiveness committee.

Milestones during Quarter 4 (January, February & March):

1. Ongoing monitoring of action plan at Locality Quality Standards meetings.

2. Review of Root cause analysis completed.

3. Q4 position: all localities to sustain 95% clinical staff compliance

4. Ongoing embedding of Engagement and Observation policy Trustwide and via Locality Quality Standards meeting following ratification.

5. Ongoing monitoring of action plan at Locality Quality Standards and Clinical Effectiveness committee.

6. Ongoing monitoring of action plan at Locality Quality Standards and Clinical Effectiveness committee.

Evidence of Impact: For this quarter

Training Compliance Q2 position:
North 68%
Cumbria 57.8%
South 69.7%
Central 68%%

Audit tool ratified as part of the Engagement and Observation policy.
Policies - Engagement And Observation Policy.pdf - All Documents (sharepoint.com)
Appendix c

Status: Partially Met

Quality Priority: Reduce waiting times in our Children's and Young People's Services (Mental Health and Neuro developmental)	**Lead: David Muir / Andy Airey** **Contributors: Aileen Boulton**

- Redesign the mental health and Neurodevelopmental pathways aiming to reduce waiting times and have standard processes across the Trust.

Milestones during Quarter 1 (April, May & June):

- Neuro workshop standardising documentation – April 23
- Establish CYPS Neuro waiting Times Task and finish Group- April 23
- Neuro Recovery planning workshop – May 23
- Neuro Workshops looking at service offer – June 23
- Mental Health Pathway workshop – June 23

Milestones during Quarter 2 (July, August & September):

- Neuro workshops focus on redesign – July
- Neuro professional groups engagement – July / August 2023
- Locality school holiday Neuro caseloads focus work – July / August 2023
- Neuro Workshop criteria for service – August 23
- Neuro workshop documentation - August 23
- Neuro task and finish group draft improvement proposal – September 23
- Neuro draft proposal review – September 23

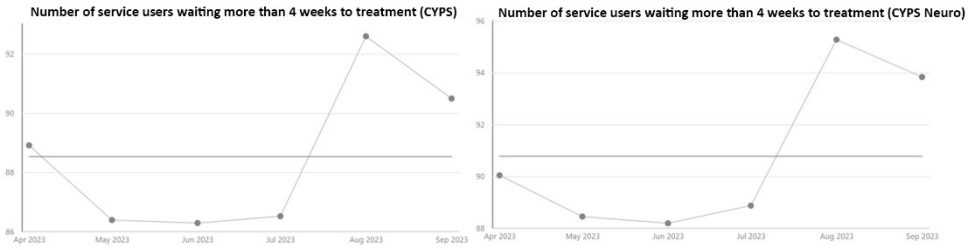
Milestones during Quarter 3 (October, November & December):

- Neuro workforce competency and training workshop – October 23
- Neuro improvement proposal review / sign off Community Oversight Group – October 23
- Neuro improvement proposal review / sign off BDG – November 23
- Neuro improvement proposal discussion with commissioners – November 23
- Neuro improvement proposal discussion with referrers – November 23
- Mental health workshop 4-week wait trailblazer – November 23
- Neuro formulation & diagnostic reporting workshop – December 23
- Neuro Locality Implementation plan development – December
- Mental health and Neuro place based needs led system developments – supported by ICB started – November 23

Milestones during Quarter 4 (January, February & March):

- Mental health workforce competency and training workshop – January 24
- Neuro workforce competency and training workshop – January 24
- Neuro Trust wide actions start implementation – January 24
- Neuro locality improvement plan start implementation – January 24
- Mental health improvement proposals – March 24

Evidence of Impact: For this quarter



- Waiting times gone down - Northumberland and South locality
- Allocated Caseloads reduced – Central Locality
- Increase in number of appointments - Northumberland and South Locality
- Reduction in number waiting following internal referral - South Locality
- Reduction in duration of those in assessment – South Locality
- Reduction in the longest waiters – Central Locality
- Increase in number of discharges – Central and South Locality

Status: Partially Met

Quality Priority : Implementation of PSIRF	**Lead: Claire Thomas** **Contributors: Peter Astbury**
○ Overall aims of the Priority here	
Milestones during Quarter 1 (April, May & June):	
• PSIRF Workstreams established	
Milestones during Quarter 2 (July, August & September):	
• Staff, service user and PSIRF engagement events held ○ The workstreams have continued to meet ○ A number of workshop and engagement events have been undertaken in Q2 these included: ▪ The compassionate engagement with those affected – staff workstream carried out a questionnaire of staff, they held a number of discussions and focus groups within localities. ▪ The compassionate engagement of those affected – patients, families and carers workstream held a workshop for a number of families who had experienced loss of a family member in our care. 1:1 discussions were held with a number of patients ▪ A workshop was held in September with to review the safety data, discuss safety priorities and PSIRF implementation. ▪ A session of the September Trust wide Leadership Forum was focussed on PSIRF and how we can compassionately engage with those affected. ▪ The PSIRF team had a stand at the Annual members meeting to answer any questions from staff or members on PSIRF.	
Milestones during Quarter 3 (October, November & December):	
• PSIRF plan and policy approved	
Milestones during Quarter 4 (January, February & March):	
• PSIRF implementation	
Evidence of Impact:	
• Feedback and learning from the engagement events and workshops held in Q2 has fed into the draft PSRIF policy/plan and the wider implementation plan for PSIRF across CNTW.	
Status: Met	

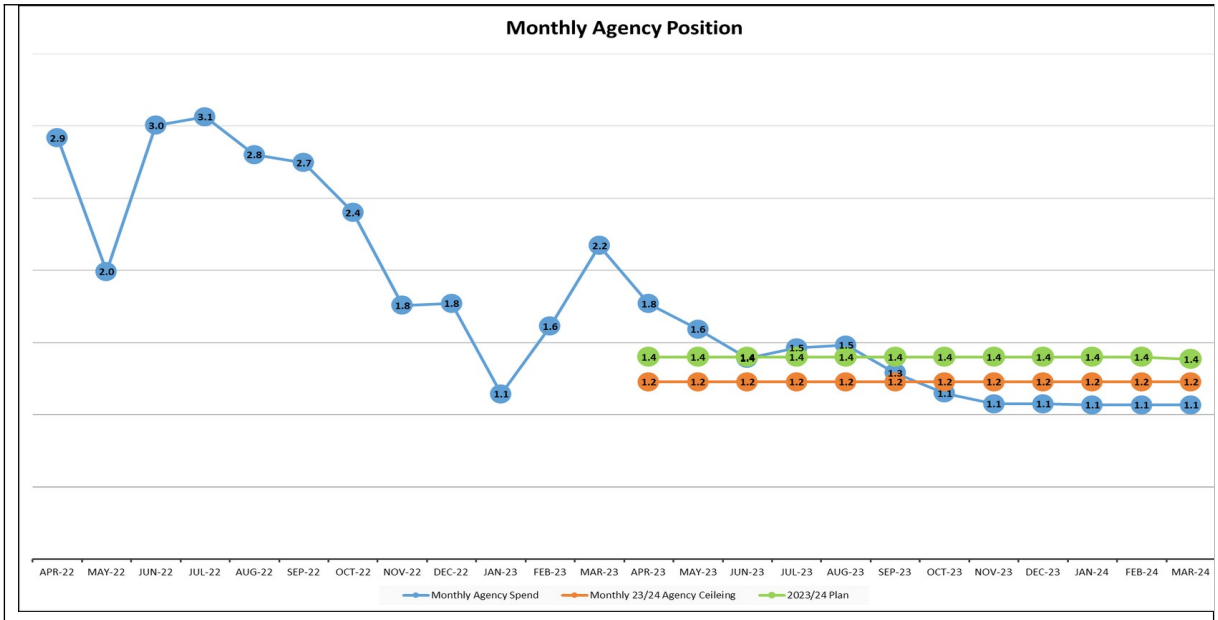
Quality Priority: Continue the work on closed cultures	**Lead: Ramona Duguid**
• Establish a 'live' process to look at early warning triggers across inpatient services. • Increase visibility and leadership visits out of hours and at weekends. • Establish the healthcare assistant development programme. • Review the response to the Edenfield recommendations to ensure they are	

embedded.
Milestones during Quarter 1 (April, May & June):
• Closed culture trigger Dashboard developed. • Central locality closed culture review – Tyne and Tweed completed. • Leadership visits in place.
Milestones during Quarter 2 (July, August & September):
• Soft' testing of dashboard in place with ward teams. • Central locality closed culture review – Tyne and Tweed completed.
Milestones during Quarter 3 (October, November & December):
• Healthcare Assistant Programme scoped and approved. • Edenfield response – 12 month progress check to be completed. • Roll out of work in Tyne and Tweed to be progressed across Secure.
Milestones during Quarter 4 (January, February & March):
• Healthcare assistant development programme launched. • Dashboard live and part of well led reviews.
Evidence of Impact: For this quarter
• Closed culture triggers included as part of CQC peer reviews. • Tyne and tweed progress on closed culture action plan.
Status: Partially Met

Quality Priority: Governance review	**Lead: Debbie Henderson** **Contributors: N/A**
The aim of this quality priority is to ensure that the organisation has a robust, clear, fit for purpose governance framework. This will enable discussions to take place at the right place, with the right people, to support the delivery of the Trust's strategic ambitions. It will also enable strong decision-making and a focus on delivery of strategic, annual and local plans and priorities.	
Milestones during Quarter 1 (April, May & June):	
A whole scale governance review was undertaken February – May 2023. The outcome of the review has resulted in changes to the corporate, operational/ management meeting structures and reporting lines. The review outcome and changes were implemented and communicated with the Trust Leadership Forum in June. The Trust intranet has been updated in respect of governance arrangements.	
Milestones during Quarter 2 (July, August & September):	
The Board of Directors were updated on the outcome of the governance review and new framework in July. The Board of Directors and Board Committees Terms of Reference has been reviewed during September and October. A further update was provided to the Trust Leadership Forum in September. Agreement has been made to undertake an internal well-led assessment against the CQC Well-led domain and will cover the implementation of the new governance framework.	

Milestones during Quarter 3 (October, November & December):
Undertake the internal Well-led review process led by Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance. Implement the new Board Assurance Framework, Risk Management Strategy and Risk Management Policy.
Milestones during Quarter 4 (January, February & March):
Outcome of the internal well-led review. Internal Audit advisory review on the implementation of the new governance framework.
Evidence of Impact:
• Governance framework and supporting documentation on the Trust intranet. • Trust Leadership Forum update • Board of Directors update
Status: Partially met

Quality Priority: Ongoing reduction with unregistered agency staff	**Lead: Ramona Duguid** **Contributors: Sheree McCartney**
• Achieve national agency cap standard (£1.2m per month) as a minimum. • Delivery of a revised bank staffing system. • Deliver revised inpatient staffing baseline.	
Milestones during Quarter 1 (April, May & June):	
• Ongoing reductions in agency.	
Milestones during Quarter 2 (July, August & September):	
• Downward trajectory being achieved for agency. • Review of trust bank scoped with targeted plan for improvement. • Inpatient staffing options scoped.	
Milestones during Quarter 3 (October, November & December):	
• Pilot of inpatient staffing baseline and enhanced MDT commenced. • Budget principles for inpatient wards to include all ward staff as part of ward budget. • Rapid improvement workshops on trust bank system concluded.	
Milestones during Quarter 4 (January, February & March):	
• Implementation of revised trust bank.	
Evidence of Impact: For this quarter	
• Ongoing reduction in agency.	



Status: Partially Met

13. PATIENT SAFETY RESPONSE FRAMEWORK PLAN

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

REFERENCES

Only PDFs are attached

13a. Cover Sheet PSIRF Policy and Plan.pdf

13b.Patient safety incident response plan v1.0.pdf

13c. Patient-safety-incident-response-policy v1.1.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**Patient Safety Response Framework (PSIRF) Policy and Plan**
Executive Lead	**Rajesh Nadkarni, Executive Medical Director / Deputy CEO**
Report author	**Claire Thomas, Deputy Director Safer Care** **Peter Astbury, Associate Director Safer Care**

Purpose of the report	
To note	
For assurance	
For discussion	
For decision	**X**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

Meetings where this item has been considered	
Quality and Performance	X
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
People	
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	X
Business Delivery Group	
Trust Safety Group	X
Locality Operational Management Group	

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 and experience	X	Service user, carer and stakeholder involvement	X

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

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Board of Directors
Wednesday 1st November 2023

Patient Safety Incident Response Framework (PSIRF) Policy and Plan

In preparation for implementation of the PSIRF NHS providers are asked to use national templates provided to write a PSIRF policy and PSIRF plan.

The policy describes the organisation's approach to responding to patient safety incidents for the purpose of learning and improvement.
This includes:

- How we will work with Patient Safety Partners
- How we will support health equality and reduce healthcare inequalities as part of PSIRF
- How we will engage with those affected by patient safety incidents
- The training offered to staff
- All relevant governance processes (including those newly designed to meet PSIRF requirements)

The patient safety incident response plan outlines our patient safety incident profile and details the methods we will use to respond in a way that maximises learning and improvement.

The documents have been developed using outputs from a number of workshops and workstreams covering different aspects of patient safety incident response. They were discussed and approved at the Trustwide Safety Group on Tuesday 17th October.

Quality and performance are asked to review and approve the documents before final approval at board and by the ICB.

Patient Safety Incident Response Plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Claire Thomas**	**Deputy Director Safer Care**		
Reviewer				
Authoriser				

Contents

Introduction

This patient safety incident response plan sets out how Cumbria Northumberland Tyne and Wear NHS FT intends to respond to patient safety incidents over a period of 12 to 18 months in line with the national Patient Safety Strategy for England (2019) and the new Patient Safety Incident Response Framework (PSIRF).

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approached to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. It is underpinned by our existing Trust Incident policy (CNTW(O)05) and associated Practice Guidance Notes (PGNs) and the new Trust patient safety incident response policy.

A glossary of terms used can be found at Appendix 1.

Our services

CNTW provides a wide range of mental health, learning disability, Autism and neuro-rehabilitation services to a population of 1.7 million people across North Cumbria and the North East of England as well as providing specialist services nationally. We are one of the largest mental health and disability organisations in the country.

We support people in the communities of North Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland working with a range of partners to deliver care and support to people in their own homes and from community and hospital based premises.

Our main hospital sites are:

- Carleton Clinic, Carlisle.
- Walkergate Park, Newcastle upon Tyne.

- St. Nicholas Hospital, Newcastle upon Tyne.
- St. George's Park, Morpeth.
- Northgate Hospital, Morpeth.
- Hopewood Park, Sunderland.
- Monkwearmouth Hospital, Sunderland; and Ferndene, Prudhoe.

Patient Safety in CNTW

CNTW Consists of four Clinical Localities supported by centralised services with dedicated focus and resource around Patient Safety:

The **Safer Care** directorate provides a comprehensive effective and sustainable culture of learning and improvement to underpin the delivery of good clinical governance. Safer Care is responsible for patient safety incident reviews, safeguarding and public protection, complaint, and claims resolution, inquest management and physical health and wellbeing.

Safer Care employs a dedicated team of Investigating Officers who have received systems approach to learning from patient safety incidents training, and training around the application of the Systems Engineering Initiative for Patient Safety (SEIPS) framework.

Investigating Officers are supported by the Safer Care management team who are amongst CNTW's six identified Patient Safety Specialists.

A Family Liaison Officer has been appointed to assist the organisation in ensuring that those involved in a patient safety incident are compassionately engaged and supported.

The **Safety, Security and Resilience** team is responsible for providing advice guidance and support in all aspects of health, safety and welfare, security management and emergency preparedness, resilience, and response. In addition, the team oversees management of the CNTW Incident Reporting system and has successfully transitioned CNTW to report into Learning from Patient Safety Events (LFPSE).

CNTW has historically employed a tiered approach to incident review. Table 1 highlights the number of formally reviewed incidents conducted across each of the last 3 full calendar years. The 2015 Serious Incident Framework has been used to identify STEIS reportable incidents for full serious incident investigation which are reviewed by the dedicated investigating officer resource. Incidents not meeting STEIS reporting criteria but identified as serious in nature by the reporter receive specialist triage from Safer Care and can then be put into the formal review tiers at 72hir review level, this process allows for escalation to Local After Action Review (LAAR) after director level review and onto full serious incident review if deemed appropriate.

All deaths reported receive Safer Care triage and a large proportion of the formally reviewed incidents in table 1 related to deaths. Any expected death / death deemed to have been because of a natural cause is triaged against the Royal Collage of Psychiatrists Mortality review tool. Through to the end of financial year 2022/3 any death meeting a red flag received a Structured Judgment Review.

Table 1 – Incident Reviews undertaken in CNTW 2020-22.

Type of Review conducted	2020	2021	2022
Full SI (STEIS)	106	83	75
Full SI (non-STEIS)	6	15	14
Local After-Action Review (LAAR)	247	273	255
72 Hour Review	0	20	192
Mortality Review	36	88	102
TOTALS	**395**	**479**	**638**

CNTW's current tiered review levels are supported by strong governance processes and as part of PSIRF this approach will remain however resources will be focused on

different types of patient safety incidents and the tiers will be supplemented by greater use of subject matter expert input, thematic analysis, swarm huddles and staff debrief.

Incidents pertaining to certain types of incidents reported in CNTW are flagged to subject matter experts for review, for example choking incidents go to the Speech and Language Therapy (SALT) team, medicines incidents to Pharmacy, safeguarding incidents to the Safeguarding and Public Protection team, and deaths to safer care.

Part of CNTW's PSIRF data review has highlighted that this function should be expanded and standardised to include regular thematic analysis of incident types that will identify potential service improvement work or indicate key lines of enquiry to inform system focused reviews up to PSII level.

Defining our patient safety incident profile

We have undertaken a comprehensive situational analysis of our current patient safety risk profile across all services within CNTW. This includes engaging with key stakeholders both internal and external and reviewing data from a variety of sources to construct a safety profile of the Trust.

The core PSIRF project team established several workstreams (figure 2) to support the preparation work required to implement PSIRF across CNTW.

Figure 2 – CNTW PSIRF Workstreams

Stakeholder engagement

The PSIRF project team have delivered many engagement events across the organisation (in person and virtually) to discuss the introduction of PSIRF and how it will change the way we review and investigate incidents across the organisation. Regular updates to Trust managers and educational forums, Trustwide Safety Group, Quality & Performance Committee and the Board have provided opportunities for further discussion and engagement in the development processes. Further staff consultation and engagement has also been undertaken in workstream 1a.

Our patients, families and carer have been engaged through the service user and carer forum and through specific engagement sessions in workstream 1b. Unfortunately, our Patient Safety Partners were not recruited in time to develop our first PSIRP but when they are recruited will play an integral role in patient safety in CNTW and in the development of future plans.

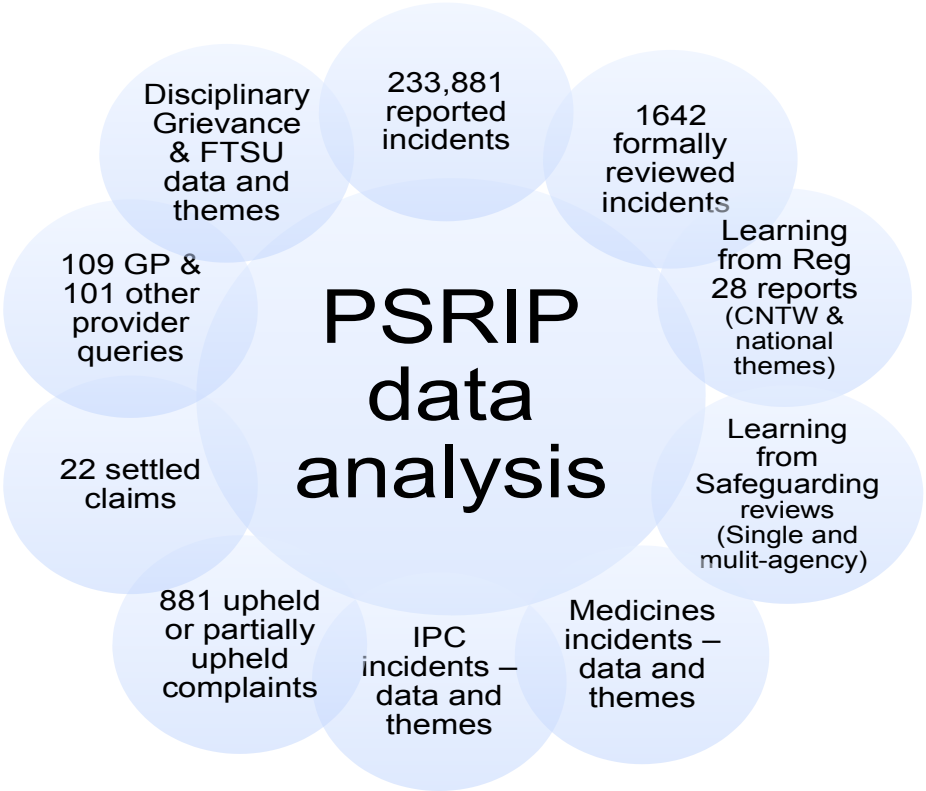
We have engaged with ICB colleagues and those in our provider collaboratives and in specialised commissioning in NHS England.

We have also linked with other Trusts regionally and nationally to learn from early adopters and others in the PSIRF development.

Data sources

We have used a range of data sources to define our safety profile (figure 3). We have also considered the feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process.

Figure 3 – Information used to collate the Trust safety profile.



Once the data was collated, we have carried out workshops with our key internal and external stakeholders to review this together to finalise our priorities, the parameters for a patient safety incident investigation and our approach to other patient safety incidents requiring a response. Where possible we have considered what any elements of the data tell us about inequalities in patient safety. As part of our workshops, we have also considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

Safety issues highlighted by the data

A number of themes were highlighted from the data which were taken into our engagement workshops. Ongoing improvement and safety work around these themes was considered and this led to the development of our local focus priorities highlighted later in this document which will be our priorities for patient safety review under PSIRF.

Whilst the final list has been agreed we are conscious that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional reviews, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Defining our patient safety improvement profile

We have collated a list of the improvement work ongoing in the Trust. This can be found in Appendix 2.

As part of the refining process of our patient safety priorities we have reflected upon the ongoing improvement work and considered if there is improvement work underway locally, at Integrated Care System level or national level that we are already undertaking to mitigate the safety risk identified.

We plan to focus our resources on the development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. However, we will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Some patient safety incidents will always require a Patient Safety Incident investigation (PSII) or other defined incident response. These have been determined

nationally. The table below describes how we will respond to patient safety incidents that meet the national event response requirements set out in PSIRF. Our new Patient Safety Incident Response Policy will describe how the insight from our learning responses feed into future patient safety improvement plans.

Patient safety event	Required response
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria)	CNTW led PSII
Incidents meeting the Never Events criteria	CNTW led PSII
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Health Capacity Act (2005) applies, where the death thought likely to be linked to problems in care (incidents meet the learning from deaths criteria)	CNTW led PSII
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an Independent PSII. A CNTW led PSII may be required
Child death	Refer to Child Death Review process. A CNTW learning response may also be required.
Deaths of persons with learning disability	Refer to Learning Disability Mortality Review Programme (LeDeR). A CNTW learning response may also be required.
Safeguarding incidents in which: • Babies, children, or young people are on a child protection / looked after plan or a victim of wilful neglect or domestic abuse/violence. • Adults with care and support needs' or 'in receipt of care and support' • The incident related to Female Genital Mutilation (FGM) Prevent (radicalisation to terrorism), modern day slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. CNTW will contribute towards domestic independent inquiries, joint targeted area inspection, child safeguarding practice review and any other safeguarding reviews (and enquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adult boards
Incidents in NHS screening programmes	Refer to local screening quality assurance services for consideration of CNTW learning response
Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	A death in prison or police custody will be referred to Prison and Probation Ombudsman (PPO) or Independent Office for Police conduct (IOPC) to carry out the relevant investigations. CNTW will fully support these investigations where required.
Domestic Homicide	A domestic homicide is identified by the police in partnership with the community safety partnership (CSP). CNTW will fully

	support these investigations where required to do so.

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of incidents and engagement meetings and workshops we have determined the Trust patient safety priorities as local focus.

Based on the local situational gap analysis and review of the local incident reporting profile, local priorities for patient safety investigation have been determined:

- Deaths
- Incidents of Violence and Aggression
- Incidents of Self Harm
- Physical Health

Within each of these broad categories there will be regular thematic reviews undertaken which will be considered by the PSLIP and escalation considered for further PSII if required.

Incident Type	Learning Response
Unexpected inpatient deaths	PSII
Natural cause death on inpatient unit	Medical Examiner process, mortality review, thematic review
Unexpected deaths with co-occurring substance misuse	ELR and thematic review LAAR can be considered by the locality directors and if required a PSII or other learning response will be considered by the PSLIP
All unexpected community deaths	All unexpected community deaths will be subject to an Early Learning Review (ELR) to ascertain if there are concerns related to care and service/treatment delivery. If concerns are raised, either through this process or by family, staff and/or other agencies, a LAAR can be considered by the locality directors and if required a PSII or other learning response will be considered by the PSLIP
Any violence and aggression incident resulting in major harm	ELR and thematic review LAAR can be considered by the locality directors and if required a PSII or other learning response will be considered by the PSLIP
Self-harm resulting in major harm	ELR and thematic review LAAR can be considered by the locality directors and if required a PSII or other learning response will be

	considered by the PSLIP

Appendix 1 - Glossary

AAR –After action review	An After-Action Review is a facilitated reflective which brings together a group of clinical and operational staff involved in the provision of care for the service user, this can include representatives from multiple teams within CNTW or external partners. The AAR will explore aspects of work within the services involved in care delivery, focusing on work as done verses work as imagined.
Deaths thought more likely than not due to problems in care	Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local plan or following reported concerns about care or service delivery. National guidance learning from deaths (england.nhs.uk)
ELR – Early Learning Review	An initial evaluation of care will be conducted via an early learning review as soon as possible following a Patient Safety Incident and within 3 working days.
Learning from Patient Safety Events (LFPSE).	The Learn from Patient Safety Events (LFPSE) service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare. NHS England » Learn from patient safety events (LFPSE) service
Never Event	Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf
AAR –After action review	An After-Action Review is a facilitated reflective which brings together a group of clinical and operational staff involved in the provision of care for the service user, this can include representatives from multiple teams within CNTW or external partners. The AAR will explore aspects of work within the services involved in care delivery, focusing on work as done verses work as imagined.
PSII - Patient Safety Incident Investigation	PSIIs are conducted to identify underlying system factors that contributed to an incident. A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These findings are then used to identify effective, sustainable improvements.
Patient Safety Strategy for England	The NHS Patient Safety Strategy sets out how the NHS will support staff and providers to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety. NHS England » The NHS Patient Safety Strategy

(2019)	
Patient Safety Incident Response Framework (PSIRF)	The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. NHS England » Patient Safety Incident Response Framework
Patient Safety Specialists	Patient Safety Specialists are individuals in healthcare organisations who have been designated to provide dynamic senior patient safety leadership. Each Patient Safety Specialist is dedicated to providing expert support to their organisation, who facilitates the escalation of patient safety issues or concerns and play a key role in the development of a patient safety culture, safety systems and improvement activity. NHS England » Patient Safety Specialists
Systems Engineering Initiative for Patient Safety (SEIPS)	Systems Engineering Initiative for Patient Safety (SEIPS) framework, an approach that looks at work systems and processes from a systems-based perspective. Patient safety incidents result from multiple interactions between work system factors. SEIPS prompts us to look for interactions rather than simple linear cause and effect relationships. SEIPS is the main model used within the Patient Safety Incident Response Framework (PSIRF) adopted by the NHS. B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf (england.nhs.uk)
SJR - Structured judgement review	Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase Patient safety incident response plan nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)
Swarm huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
Thematic reviews	A themed review may be useful in understanding common links, themes or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using reference cases (e.g., individual incidents or previous investigations).

Safety Themes	Programmes/projects	Aims	Teams/staff involved
Clinical service provision Patient care Access Suicide prevention IG	Place-based transformation of community mental health services	To improve the local offer for the people of a particular place, by developing new partnerships and improved interfaces	All adult community teams in the first instance 7 Pioneer adult CTTs, one from each locality
Clinical service provision Patient care Access Suicide prevention Admission/discharge processes	Clinical model development	To improve the effectiveness of clinical service delivery across adult and older people's pathways (including rehabilitation, complex emotional needs, and assertive outreach developments)	All adult community teams in the first instance, and interfacing services
Medication	Increased use of Clozapine	To expand the use of Clozapine via improved community delivery approaches	All adult community teams in the first instance

Appendix 2 – CNTW Improvement Programmes

Safety Themes	Programmes/projects	Aims	Teams/staff involved
Clinical service provision Patient care IG	Person-centred care planning (moving away from CPA)	To reduce the bureaucracy of previous Care Programme Approach and of RiO, in parallel to the development of new place-based partnership models of care planning	All adult and older people's community teams to test the approach in the first instance
Clinical service provision Patient care Suicide prevention Medication IG	Improving access to children's services, and effectiveness of service delivery	To work with partners to develop an improved needs-led model of access, support and treatment for children and young people. To improve flow within and between pathways, and to improve the effectiveness of treatment pathways, including a focus on reducing admissions and reducing use of medication (STOMP/STAMP)	All CYPS teams across the Trust, in collaboration with partners, including eating disorders and Neuro-developmental services/pathways
Inpatient environment Clinical service provision Inpatient safety Suicide prevention	CEDAR Ferndene	To implement the improved clinical model, in liaison with estates on the build programme, and in that, to support operations with decant planning	All CYPS wards

Safety Themes	Programmes/projects	Aims	Teams/staff

			involved
Clinical service provision Patient care Inpatient environment Inpatient safety (e.g., violence, self-harm, sexual safety, IPC) Suicide prevention	Quality Framework for inpatient services	To increase the quality of the inpatient experience, and deliver against key standards	All working age adult acute wards in the first instance
Clinical service provision Patient care Inpatient safety Suicide prevention	Effective inpatient pathway	To improve flow through inpatient areas whilst delivering high quality care	All working age adult acute wards in the first instance
Inpatient staffing Clinical service provision Patient care Inpatient safety Suicide prevention	Inpatient staffing	To improve the effectiveness of inpatient staffing, including a focus on the role of the MDT and the associated therapeutic offer, and in that, reducing the need for temporary staffing	All working age adult acute wards in the first instance Bank team

Safety Themes	Programmes/ projects	Aims	Teams/staff involved
Clinical service provision/access Patient care Suicide prevention	Crisis and liaison workstreams	To improve the effectiveness of the crisis and liaison offers, including their interfaces with each other, with Police via S136, and with community teams/partners. In that, to develop new interfaces with 111	All crisis teams. Liaison – central and north teams
Inpatient staffing Patient care	E-rostering	To introduce e-rostering of inpatient staffing using the Allocate system, with the aim to improve use of resources	All inpatient wards
Inpatient safety Suicide prevention	Oxevision	To rollout Oxevision across inpatient services, as part of the improving safety programme	All inpatient wards
Clinical service provision Patient care Staffing	ESR upgrade	To rollout out the upgrade of the ESR system, including changes to leave, skills and appraisal recording (with links to Allocate)	Trustwide

Safety Themes	Programmes/projects	Aims	Teams/staff involved
Environment IPC	Implementation of central stores model	Reduction in waste, improved efficiency	All wards at Hopewood Park
Environment Patient care IPC	Improved ward environments - KDU	Improved ward environments	KDU Northgate
Patient care	Lamesley improvement plan	A range of projects including: • Protected time for paperwork • Creating capacity for nurse teams (day and night shifts) • Care planning	Lamesley ward team
Patient care	MDT approach - Walkergate Park wards 1 and 2	MDT improvements	Ward teams and wider MDT

Safety Themes	Programmes/projects	Aims	Teams/staff involved
Medication	Medicine round improvements - Shoredrift	Improved medicine rounds	Ward team
Patient care	Kinnersley improvement project	To improve the effectiveness of day to day operations	Kinnersley ward team
Patient care IPC Patient safety	Woodhorn improvement project	To improve the effectiveness of day to day operations Covid response plan	Woodhorn ward team
Environment Patient care	Brooke House environment	To improve the environment and efficiency	Brooke House team

Patient safety incident response policy

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Claire Thomas**	**Deputy Director Safer Care**		
Reviewer				
Authoriser				

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Cumbria Northumberland Tyne and Wear NHS FT's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

This policy should read in conjunction with our Patient Safety Incident Response Plan, which is a separate document setting out how this policy will be implemented.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust**.**

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes such as those listed below and are therefore outside of the scope this policy.

- Claims
- Human resources investigations into employment concerns
- Professional standards investigations
- Coronial inquests and criminal investigations
- Information Governance concerns
- Financial investigations and audits
- Safeguarding concerns
- Complaints (except where a patient safety concern is highlighted)

The Trust considers these processes to be separate from any patient safety investigation. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust aims to create a restorative just and learning culture of openness, in which staff do not feel afraid of reporting adverse events or feel blamed when they are involved in an incident. In this way learning can take place and improvements made locally which can be shared across the Trust and potentially across the Integrated Care System.

The main goals of restoration when an incident has happened have been outlined as follows:

- Organisational Learning
- Prevention
- Moral engagement
- Emotional healing
- Reintegration of the practitioner

PSIRF will enhance these goals by creating much stronger links between a patient safety incident and learning and improvement. We will work collaboratively with all those affected directly or indirectly by a patient safety incident – staff, service users, families, carers to determine the learning and improvement required and foster a

culture openness and transparency when things have not gone as planned as well as sharing and celebrating insight and success when things have gone well.

The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place. There is a range of support and information available:

- The Patient Safety Team will advise, and signpost staff involved in patient safety incidents to the most appropriate information and support.
- The Trust employee assistance scheme, Vivup which has a 24/7 support line 0330 380 0658.
- Staff Psychological Centre
- Occupational Health
- Schwartz Rounds. Sessions are themed and provide a structured forum and safe space where staff come together to discuss the emotional and social impact of working in healthcare. You can join the conversation, share your experience or simply listen to their stories.
- Freedom To Speak Up Guardians - A confidential service for staff if they have concerns about the organisation's response to a patient safety incident.
- Trade Union Representatives
- Equality, Diversity and Inclusion Team
- Cultural Ambassadors
- Workforce and OD teams
- Chaplaincy
- The Trust is currently developing a post-vention support package.

We are committed to analyse findings from our staff survey metrics based on specific patient (and staff) safety questions, as well as other internal measures to assess if we are sustaining our ongoing progress in improving our safety culture.

Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation). This is a new role across the NHS and will evolve over time.

Patient Safety Partners are a key element to ensuring successful implementation of the PSIRF within the Trust. The aim will be to support Patient Safety Partners to transfer their individual experience and expertise to compliment the Trust patient safety response.

The PSPs will be supported in their role by the Patient Safety Specialists for the Trust who will provide expectations and guidance for the role. They will have regular scheduled reviews and regular one-to-one sessions and training needs will be agreed together based on the experience and knowledge of each PSP. There is an expectation that they will undertake the training required to the national standard for their role as specified in the National Patient Safety Syllabus as well as other relevant training.

Initial roles for Patient Safety Partners may include participating and joining key conversations and meetings within the Trust that address patient safety, learning and improvement and being involved with contributing to documentation including policies, investigations, and reports. As the role evolves, we may ask PSPs to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure PSPs have the essential tools and advice they need.

Addressing health inequalities

Cumbria Northumberland Tyne and Wear Trust is committed to addressing those health inequalities experienced by people with mental illness. We have workstreams tasked with reducing physical health inequalities through delivery of annual health checks, screening programmes, vaccination and modifiable interventions around physical exercise, weight management, smoking and drug and alcohol misuse. We are working within the ICB to address the inequalities highlighted within the Core20PLUS5 agenda.

In addition, the trust already has in place a programme of work which is utilising national and aggregated Trust level data to identify where multiple physical illnesses have contributed to premature death. This will enable the identification of priorities for further investigation and the development of safety action plans to address issues at a system and population level.

Several identified populations have difficulty in accessing timely and appropriate mental health care or experienced higher levels of mental illness. This can be related to, amongst others, ethnicity, gender, deprivation, and age.

A flexible approach to patient safety incident response processes will enable the Trust to enhance this work by facilitating detailed exploration of individual service user journeys where premature death or other adverse outcome has been associated with avoidable physical health conditions or delays to access to appropriate care and

treatment. Such findings will contribute to the development of safety actions and quality improvement programmes.

Involvement of service users, families and staff is key to ensuring that safety actions are identified and effectively addressed. Barriers to involvement will be addressed through the use of the family liaison officer and occupational wellbeing services supplemented, where applicable by peer supporters, language translation and easy read communications.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

CNTW recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. Ensuring involvement right with patients and families in how we respond to incidents is vital, particularly to support improving the services we provide.

In line with our Trust value of 'being open and honest, the Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned or when a mistake has been made. This is regardless of the level of harm caused by an incident.

There is a responsibility as a statutory requirement under CQC Regulation 20, Duty of Candour for all healthcare organisations to be open and transparent with patients and their families when things go wrong with treatment or care delivery. Registered professionals should also refer to their professional guidance with reference to Duty of Candour requirements. This forms the basic principle of the Trust's 'Being Open' – Fulfilling our Duty of Candour (CNTW(O)05 – IP-PGN-06). Where it has been identified that an incident is suspected of causing moderate or severe harm, or death, then the Statutory Duty of Candour must be enacted by the Clinician responsible for the care of the patient. Adhering to Being Open principles however is good practice and the Trust encourages being open with patients and their families regardless of level of harm. It is the responsibility of the Locality to ensure all Duty of Candour requirements are met. This will be underpinned by support from the Family Liaison Officer who can guide staff

to ensure patients, families and carers are supported through any investigation or learning review.

Equally we recognise the impact that a patient safety incident may have on staff. CNTW is committed to a just, open and restorative culture to learning from safety incidents. We will work with our staff teams, our union representatives and our leadership teams to ensure we are engaging compassionately with staff and are offering a systems approach to understanding and sharing learning, while also ensuring sustained, compassionate support is available to staff.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

Resources and training to support patient safety incident response.

The Trust endorses the completion of the National – Health Education England Patient Safety Syllabus modules.

All staff, clinical and non-clinical are expected to undertake the Level 1 module (Essentials for patient safety), on induction and repeated each three years. These modules are available as eLearning via ESR access.

Board and Senior Leaders are expected to undertake the Level 1 module - Essentials of patient safety for boards and senior leadership teams which can be accessed directly from the Health Education England eLearning for healthcare platform or ESR.

All clinical staff at AFC Band 7 or above, with potential to support or lead patient safety incident management are expected to undertake the level 2 module - Access to Practice. This module is available as eLearning via ESR access.

To allow effective learning from Patient Safety Incidents and ensure actions leading to sustainable improvements it is important to ensure those involved in the responses have adequate capacity and competency. The Patient Safety Incident Responses will fall into four main categories:

- Early Leaning reviews (completed by an appropriately trained clinician within 72 hours)
- After Action reviews (A facilitated reflective discussion with staff delivering services / care facilitator to be appropriately trained in Systems based methodologies)
- Patient Safety Incident Investigation (In depth systems-based investigation completed by dedicated investigating officers trained in Human Factors and systems-based approach)
- Thematic Reviews (completed routinely by subject matter experts / dedicated investigating officers in line with safety priorities, emerging safety concerns and completed learning responses)

Early Learning Review (ELR)

An initial evaluation of care will be conducted via an early learning review as soon as possible following a Patient Safety Incident and within 3 working days. The Early Learning Review will be requested by the Clinical Risk and Investigations department and be completed by either a dedicated Investigating officer or an appropriately trained clinician (band 7 and above) from the service area.

Training for Early Learning reviews will be completed via an internal Trust training course led by the Clinical Risk and Investigations Department. Training will be available to all staff tasked with supporting, facilitating, and signing off Learning reviews,

The Early Learning review is designed to occur quickly following the Patient safety incident and involves as desktop review of records and discussion with those immediately involved or affected. This should allow identification of any locally required actions to address safety concerns, process and systems issues and translate into quick action to resolve.

The Early learning response will be reviewed by the Locality directors for approval and determination as to whether further learning may be identified via escalation to AAR, or consideration by PSLIP for PSII.

After Action Review (AAR)

An After-Action Review is a facilitated reflective session to be utilised if it is determined further learning may be obtained following ELR. These learning responses will be

completed within 40 working days. AAR's will be facilitated by either a dedicated Investigating officer or an appropriately trained clinician (band 7 and above) from the clinical locality.

While the ELR will focus on the specific incident and involve input from those directly involved or affected, the AAR will bring together a wider pool of clinical and operational staff involved in the provision of care for the service user, this can include representatives from multiple teams within CNTW or external partners. The AAR will explore aspects of work within the services involved in care delivery, focusing on work as done verses work as imagined. This will utilise the patient safety incident and the ELR as a basis for the discussion, however, will focus on care delivery more generally within the locality / localities involved.

Training for After-Action Reviews will be completed via an internal Trust training course led by the Clinical Risk and Investigations Department. Training will be available to all staff tasked with supporting, facilitating, and signing off Learning reviews.

The AAR will be reviewed by the Locality directors for approval and determination as to whether consideration by PSLIP for PSII should occur.

Patient Safety Incident Investigation

PSIIs will be completed for all:

- Never Events
- Deaths of patients detained under the MHA / MCA where death is linked to gaps in care.
- Inpatient suicide
- Homicide perpetrated by a service user in receipt of care at the time of the incident or discharged in the preceding 6 months.
- Deaths thought more likely than not due to problems in care (identified following ELR / AAR / Mortality Review)

Other incidents will be investigated via PSII where the Patient Safety Learning and Review Panel (PSLIP) considers that potential learning is significant and complex to a degree that it will require an extensive investigation to fully understand any systems and process issues and implement appropriate service / quality improvement.

PSIIs will be led by the dedicated Investigating Officers based within the Clinical Risk and Investigations Department support will be provided by expert advisors as required from Clinical and/or Operational teams. The Investigation Officers will all be educated in SEIPS methodology and will receive support and supervision from Learning Response Leads and Patient Safety Specialists.

The Trust will liaise with those effected by Patient Safety Incidents and jointly consider the level of involvement those individuals would like to have in the investigation process. This consideration will be led by the Family Liaison Officer (service users / carers / families) and the relevant Associate Director (CNTW staff).

Thematic Reviews

Thematic reviews will be conducted on a regular basis to identify themes and trends evident from their routine reviews of certain incident types.

Completed ELR and AAR's will also be subject to routine thematic review to identify themes and trends that may be emerging in certain services, localities or across the organisation.

The outputs of thematic reviews will be discussed at PSLIP where it may be determined that a specific issue would benefit from a PSII, should be linked to an ongoing Trust improvement initiative, or to determine the need for a new Trust improvement initiative.

It may also be appropriate for a locality to request a thematic review via their weekly safety meeting if low level incidents are identified to be reoccurring or any new safety concern is felt to be emerging.

Swarm huddles

A swarm huddle may be used to support the Trust response to a significant incident and / or concern. The swarm huddle is designed to be initiated as soon as possible after an event to ensure the co-ordination of immediate action and learning. This will involve an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

A swarm will be agreed by executives and will have a delegated Locality Director lead.

Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident on a Trust incident reporting system and will record the level of harm they know has been experienced by the person affected in line with Trust Practice Guidance (Incident Reporting and Management CNTW(O) 05 – IP-PGN-01).

All Patient Safety Incidents will initially be reviewed by the identified Manager for the location that the incident was reported in. This initial managerial review will ensure that the information reported within the incident form is accurate and complete.

Localities will have review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely manner. This should include consideration and prompting to clinical teams where Duty of Candour applies (See Trust policy 'Being Open' – Fulfilling our Duty of Candour (CNTW(O)05 – IP-PGN-06).). Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated to the Clinical Risk and Investigations Team.

Teams and Localities will highlight to the Clinical Risk and Investigations team any incident which appears to meet the requirement for reporting externally. This may be to

allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

Patient safety incident response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan (insert link here).

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and to revise our toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents to ensure robust governance and oversight is in place.

The Trusts web-based reporting and notification system will be utilised to ensure that incidents in relation to PSII requirements and safety priorities are identified to both the central Clinical Risk and Investigations department as well as relevant subject matter experts for triage and review. The system in place will also allow for review of incidents from a wide range of patient safety incident types that may after consideration require a PSII.

Outside of mandatory PSII's, CNTW's established tiered approach to incident review and escalation has been reviewed and will be supplemented with additional systems-based approaches and review tools to better utilise available resources and strike a balance between reviewing for learning and service improvement work.

The web-based reporting system will include initial incident review across a range of incident categories and allow for local consideration of learning responses including Early Learning reviews (ELR), After Action Reviews (AAR) and escalation of patient safety incidents / concerns to the CNTW Patient Safety Learning and Improvement Panel (PSLIP).

CNTW Patient Safety Learning and Improvement Panel (PSLIP).

PSLIP will meet routinely and will consist of a multi-disciplinary group of senior staff with operational, clinical, patient safety and quality improvement expertise, this group will include CNTW's patient safety specialists and patient safety partners.

Regarding PSII's. PSLIP will have delegated responsibility for agreeing terms of reference, timescales and sign off. PSLIP will be able to request PSII's outside of mandatory requirements where it is identified via ELR's / AARs and thematic reviews that a safety concern exists that is not fully understood or is not already the subject of current improvement work. PSLIP will also have the authority to establish improvement work where required.

PSLIP will ensure that learning is shared via the trusts identified local and Trustwide learning forums and will have oversight of assurance around the embedding and impact of learning.

PSLIP will report to The Trustwide Safety Group (TSG) which will have overall oversight of patient safety and will offer challenge to PSLIP to ensure that the Board can be assured that the true intent of PSIRF is being implemented and that CNTW are meeting the national patient safety incident response standards.

Any incident highlighted for a Learning response will follow the process outlined below which can be seen in diagram form in Appendix 1

Local level incidents –Incidents where it is not immediately apparent that a Learning response is required will be reviewed in the first instance by local managers who are notified of incidents in their service areas by the Web based incident reporting notification system. Service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area as soon as is practicably possible, this response should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible, this process of manager review and sign off, of immediate remedial patient safety actions should not take longer than 5 days. Adherence to this timeframe will be monitored via the weekly locality safety meeting. Immediate remedial actions may include for example, withdrawing equipment or use of a short-term intervention such as seclusion. Any response to an incident should be fed back to those involved or affected and appropriate support offered, this could take the form of a debrief see: Policies - Positive And Safe Management Of Post-Incident Support And Debrief.pdf - All Documents (sharepoint.com)

Where Duty of Candour applies this must be carried out according to Trust guidance. see: Policies - PGN - 06 - 'Being Open' - Fulfilling our Duty of Candour.pdf - All Documents (sharepoint.com)

Locality safety meetings may commission thematic reviews of such incidents to consider and understand potential emerging risks. The outputs of such reviews would then be fed into PSLIP for consideration of next steps.

Incidents with positive or unclear potential for PSII – all staff (directly via the web-based reporting system, through their line manager or manager on call) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event. Duty of Candour disclosure should take place according to Trust guidance (see above link).

Where it is clear a PSII is required (for example, for a Never Event or Inpatient Suicide) the Clinical Risk and Investigations Department will direct that an ELR is undertaken, and that relevant internal and external escalation / reporting is completed. The completed early learning review may generate local safety actions which will be locally managed and be reported into the locality safety meeting. The ELR will also be discussed at the next PSLIP, and decisions will be made about TOR' s / Scope and timescales. An Investigating officer will be appointed via the Clinical Risk and Investigations Department who will then commence the PSII.

Other incidents with unclear potential for PSII, must also be reported to the Clinical Risk and Investigations Department via the web-based reporting system where they will be triaged. Where required an ELR or AAR may be indicated, post learning response, if uncertainty remains around level of review, they will be taken to PSLIP for consideration for PSII.

The Clinical Risk and Investigations team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, Clinical Risk and Investigations will work with the localities to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

Trustwide Safety Group (TSG)

TSG is an Executive-led Patient Safety Group and will oversee the operation and decision-making of the PSLIP and the incident responses it has delegated responsibility to commission. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

Responding to cross-system incidents/issues

Where an incident is identified as presenting potential for significant learning and improvement for another provider, the clinical risk and investigations team will liaise directly with that organisation's patient safety team or equivalent.

The Trust will work with other providers and the ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Clinical Risk and Investigations team will act as the liaison point for such working.

The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Timeframes for learning responses

Managers review / sign off will be completed within 5 working days of an incident being reported.

Early Learning Reviews (ELR) will be completed within 3 working days from the date of request.

Local After Action Reviews will be completed within 40 days from the date of request.

PSIIs will see timescales agreed at the Patient Safety Learning and Improvement Panel with a maximum time period of up to 6 months. The time period agreed will include timescales for investigation, identification of areas for improvement and development of an action plan. All stages will be completed within the agreed timescale (maximum of 6 months).

Safety action development and monitoring improvement

Any patient safety learning response will allow the circumstances of an incident or set of incidents to be understood, but that this is only the start of a process. To reduce the risk of re-occurrence, safety actions need to be developed, implemented and monitored.

The Trust will have systems and processes in place to design, implement and monitor safety actions. The investigation process of any learning response might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. Safety actions will be developed for each of these defined areas for improvement.

Safety Actions must be developed with the clinical and operational teams that will implement these actions to ensure ownership of the actions and outcomes.

Safety Actions must be clearly defined, describe responsibilities and timescales, aligned to reportable outcome measures, and include a detailed assurance / monitoring process.

Safety actions must continue to be monitored within the Locality governance arrangements to ensure that any actions put in place remain impactful and sustainable. Locality Quality Standards and Trustwide Safety Group will have oversight of any outstanding safety actions.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues.

The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

Safety improvement plans will be considered by the Lessons Learned Forum both to receive progress and assurance regarding existing plans but also to recommend the need for future improvement plans following review of responses and individual safety actions. There will be a clear alignment between some safety actions falling out of individual patient safety responses and the overarching safety improvement plans, these plans will often lead to the outcome measurement and assurance processes that underpin safety actions.

Oversight roles and responsibilities

Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures. The national guidance provides 'mindset principles' which underpin our response to patient safety incidents.

1. Improvement is the focus PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.
2. Blame restricts insight Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
3. Learning from patient safety incidents is a proactive step towards improvement Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.
4. Collaboration is key A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.
5. Psychological safety allows learning to occur Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
6. Curiosity is powerful Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

Responsibilities

The PSIRF gives organisations clear responsibilities for oversight. To meet these responsibilities, the Trust has designated the Executive Medical Director as the PSIRF executive lead. They will support the responsibilities outlined below and provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required.

1. Ensuring that the organisation meets the national patient safety standards.

The Executive Medical Director will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards.

To achieve the development of the plan and policy the Trust will supported by internal resources within the Safer Care team led by the Deputy Directors of Safer Care who report to the Executive Medical Director.

2. ***Ensuring that PSIRF is central to overarching safety governance arrangements.***

The Trust board have had regular updates during the development of the PSRIF Policy and plan including the impact of changes following incidents.

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality & Performance Committee. The Quarterly Safer Care reports will include information to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

The Trustwide Safety Group will provide assurance to the Quality & Performance Committee that PSIRF and related workstreams have been implemented to the highest standards. Localities will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

Localities will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

3. Quality assuring learning response outputs

The Trust will implement a central Patient Safety Learning Improvement Panel to ensure that PSIIs and other learning responses are conducted to the highest standards, ensure that learning and areas for improvement are identified, safety actions and improvement plans are appropriate and robustly monitored, and to support the Executive sign off process.

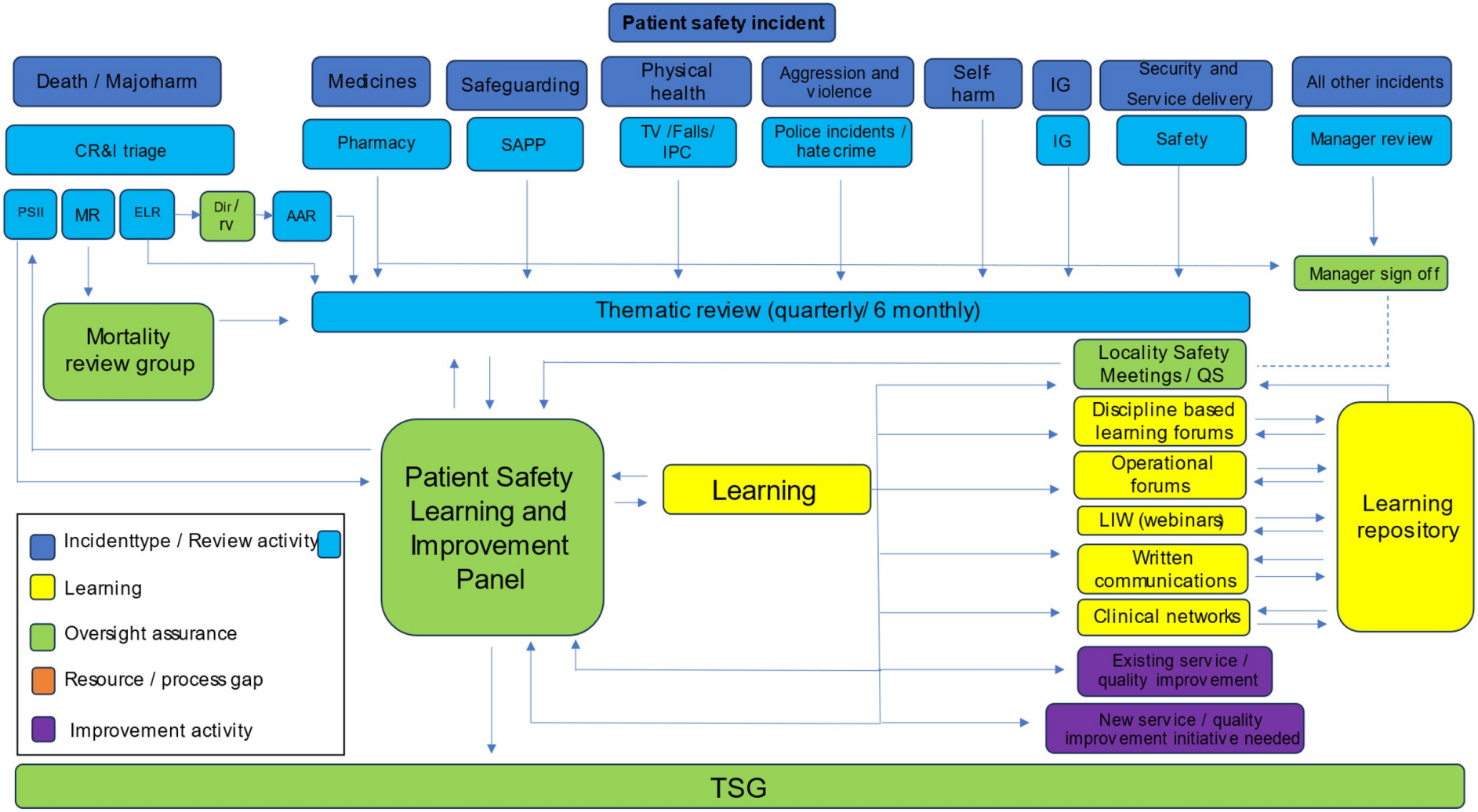
Updates will be made to this policy and associated plan as part of regular oversight. A full review of this policy and associated plan should be undertaken at least every four years alongside an assessment of the delivery of all safety actions.

Complaints and appeals

The Trust is focused on quality improvement and supporting those affected by patient safety incidents, therefore it is expected that all actions to support a proportionate and

thorough investigation following a patient safety event will be delivered. This process should be fully inclusive of the considerations for those affected by the incident, however where patients and or families / friends do not feel the response to the patient safety incident has been appropriate or that they have not been supported appropriately a right to raise a concern or complaint will remain. All people affected by a patient safety incident who wish to raise a concern or complaint can do so via the Trust Complaints Team on 0191 245 6678 or by email complaints@cntw.nhs.uk or by post to Complaints Team, St Nicholas Hospital, Gosforth, Newcastle Upon Tyne, NE3 3XT.

Appendix 1 – Learning response process.


Patient safety incident
Death / Major harm
Medicines
Safeguarding
Physical health
Aggression and violence
Self-harm
IG
Security and Service delivery
All other incidents
CR&I triage
Pharmacy
SAPP
TV /Falls/ IPC
Police incidents / hate crime
IG
Safety
Manager review
PSII
MR
ELR
Dir / rv
AAR
Manager sign off
Thematic review (quarterly/ 6 monthly)
Mortality review group
Locality Safety Meetings / QS
Discipline based learning forums
Operational forums
LIW (webinars)
Written communications
Clinical networks
Learning repository
Patient Safety Learning and Improvement Panel
Learning
Existing service / quality improvement
New service / quality improvement initiative needed
Incidenttype / Review activity
Learning
Oversight assurance
Resource / process gap
Improvement activity
TSG

14. EQUALITY, DIVERSITY AND INCLUSION IMPROVEMENT PLAN

Lynne Shaw, Executive Director of Workforce and OD

REFERENCES

Only PDFs are attached

14. NHS Equality Diversity and Inclusion For Trust Board November 2023.pptx

15. GUARDIAN OF SAFE WORKING REPORT

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

REFERENCES

Only PDFs are attached

15. GOSW Quarter 2 Report October 2023.pdf

Name of meeting	**Trust Board**
Date of Meeting	**1 November 2023**
Title of report	**Guardian of Safe Working Quarterly Report – July to September 2023 – Q2**
Executive Lead	**Dr Rajesh Nadkarni, Executive Medical Director**
Report author	**Dr Clare McLeod, Guardian of Safe Working**

Purpose of the report	
To note	**X**
For assurance	**X**
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	
2. Person-led care, when and where it is needed	
3. A great place to work	X
4. Sustainable for the long term, innovating every day	
5. Working with and for our communities	

Meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
People Committee	X
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience		Service user, carer and stakeholder involvement	

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

Trust Board

Wednesday 1 November 2023

Guardian of Safe Working Quarterly Report July to September 2023 – Q2

1. Executive Summary

This is the Quarterly report for the period July to September 2023 for Safe Working Hours which focuses on Junior Doctors. The process of reporting has been built into the new junior doctor contract and aims to allow Trusts to have an overview of working practices of junior doctors as well as training delivered.

The new contract is offered to new trainees' as they take up training posts, in effect this will mean for a number of years we will have trainees employed on two different contracts. It is also of note that although we host over 160 trainee posts, we do not directly employ the majority of these trainees.

There are currently 169 trainees working into CNTW with 169 on the new Terms and Conditions of Service via the accredited training scheme via Health Education England. There are an additional 13 trainees employed directly by CNTW working as Trust Grade Doctors or Teaching/Research/Clinical Fellows.

High level data

Number of doctors in training (total): 169 Trainees (as at 5 October 2023)

Number of doctors in training on 2016 TCS: 169 Trainees (as at 5 October 2023)

Amount of time available in job plan for Guardian to do the role: This is being remunerated through payment of 1 Additional Programmed Activity

Admin support provided to the Guardian (if any): Ad Hoc by Medical Education Team

Amount of job-planned time for educational supervisors: 0.5 PAs per trainee

Trust Guardian of Safe-working Hours: Dr Clare McLeod

2. Key issues, significant risks and mitigations

- 24 Exception Reports raised during the period July to September 2023. All were due to hours and rest. Time Off in Lieu (TOIL) was granted for 14, payment was made for 1 and 9 are yet to be responded to.
- 1 Agency Locum was booked during the period covering vacant posts.
- 181 shifts lasting between 4hrs and 12hrs were covered by internal doctors.
- On 5 occasions during the period the Emergency Rotas were implemented (either by rota collapse or training rota covering a shift).
- 7 IR1s submitted due to insufficient handover of patient information.
- 8 Fines received during the quarter due to minimum rest requirements between shifts not being met.

Exception reports (with regard to working hours)

		Exception Reports Received July to September 2023				
Grade	Rota	July	Aug	Sept	Total Hours & Rest	Total Education
CT1-3	St Nicholas	1	6	1	8	0
CT1-3	Hopewood Park	0	0	3	3	0
CT1-3	RVI/CAMHS	0	0	0	0	0
CT1-3	NGH/CAV	0	0	0	0	0
CT 1-3	St George's Park	0	0	0	0	0
CT 1-3	GHD/MWM	0	0	0	0	0
CT 1-3	Cumbria	0	0	0	0	0
ST4+	North of Tyne	0	3	0	8	0
ST4+	South of Tyne	0	1	4	0	0
ST4+	CYPS (NR)	2	0	1	3	0
CT1-ST6	Neuro Rehab (NR)	2	0	0	2	0
Total		**5**	**10**	**9**	**24**	**0**

Work schedule reviews

During the period July to September 2023 there have been 24 Exception Reports submitted by Trainees, all for hours and rest. The outcome of which was that TOIL was granted for 14 cases, payment made for 1 case and 9 cases still to be responded to.

a) Locum bookings - Agency

Locum bookings (agency) by department			
Site	July	August	September
RVI	1	0	0
Total	**1**	**0**	**0**

Locum bookings (agency) by grade			
	July	August	September
F2	0	0	0
CT1-3	1	0	0
ST4+	0	0	0
Total	**1**	**0**	**0**

Locum bookings (agency) by reason			
	July	August	September
Vacancy	0	0	0
Sickness/other	1	0	0
Total	**1**	**0**	**0**

a) Locum work carried out by trainees

Area	Number of shifts worked	Number of shifts paid at enhanced rate	Number of shifts to cover sickness	Number of shifts to cover OH Adjustments	Number of shifts to cover special leave	Number of shifts to cover a vacant post
SNH	13	2	2	7	0	4
SGP	17	10	6	11	0	0
Northgate	12	5	2	6	1	3
MWM/GHD	25	14	11	8	3	3
Hopewood Park	13	7	4	5	0	4
RVI	14	7	6	8	0	0
NGH	16	11	3	12	1	0
Cumbria	34	12	7	8	0	19
North of Tyne	24	3	7	17	0	0
South of Tyne	13	10	8	0	5	0
CAMHS	0	0	0	0	0	0
Total	**181**	**81**	**56**	**82**	**10**	**33**

* 81 shifts were offered at an enhanced rate of £50 for 1st & £60 for 2nd on call rotas

b) Vacancies

Vacancies by month				
Area	Grade	July	August	September
SGP	CT	0	1	1
	GP	1	0	0
	F2	0	0	0
RVI	CT	2	0	0
	GP	0	0	0
	F2	0	0	0
NGH	CT	0	0	0
	GP	0	1	1
	F2	0	1	1
HWP	CT	0	0	0
	GP	2	0	0
	F2	0	0	0
MWH/GHD	CT	0	0	0
	GP	1	0	0
	F2	0	0	0
Total	CT	**2**	**1**	**1**
	GP	**4**	**1**	**1**
	F2	**0**	**1**	**1**

c) Emergency Rota Cover

Emergency Rota cover is arranged when no cover can be found from either Agency or current Trainees. The rotas are covered by 2 trainees rather than 3 and payment is made to the 2 trainees providing cover at half rate.

Emergency Rota Cover by Trainees/Consultant*				
	Rota	July	August	September
Sickness/Other	NOT	0	0	0
	SOT	0	0	0
	SGP	0	0	0
	Northgate	0	0	0
	SNH	1	0	0
	RVI	0	0	0
	GHD/MWM	0	0	0
	Cumbria	0	1	0
	HWP	0	0	0
	NGH	0	1	0
Total		**1**	**2**	**0**

d) Training Rota Cover

The training rota doctor can be asked to cover a gap in the standard rota to prevent the use of the emergency rota cover with the provision of alternative opportunities for this training.

Training Rota Cover by First on-call Trainees				
	Rota	July	August	September
Sickness/Other	SGP	0	0	0
	SNH	0	0	0
	RVI	0	0	0
	GHD/MWM	1	0	0
	HWP	1	0	0
	NGH	0	0	0
Total		**2**	**0**	**0**

e) Fines

There were 8 fines issued during this quarter due to 6 separate trainees breaching the 13-hour shift limit and having less than 11 hours rest between shifts or insufficient rest during a non-resident on-call shift. It was agreed at the Guardian of Safe Working (GoSW) forum in September that fine money should be spent on take-away pizzas at training events across the Trust. This will be implemented once the final sum is clarified so that the money can be distributed equitably by numbers of trainees in each Trust site.

Issues Arising

There have been 24 exception reports submitted this quarter. This represents an increase from the previous quarter when there were twelve exception reports submitted and compared to the same period last year when there were also twelve exception reports.

Half of the exception reports have been submitted by higher trainees which is an increase from the usual both in CNTW and other Trusts, with higher trainees underreporting in general. The increase is from all the higher training rotas and from several different trainees so does not highlight a particular rota or region of concern. Some of this increase represents more complete reporting which is encouraging. However, it also highlights that long-day shifts can be busy with MHA work. This was discussed at the forum in September with potential ways of managing this and supporting the higher trainees to be explored further at the forum in November.

Four exception reports in this quarter came from the non-resident on-call rotas (CYPS and Neuro-rehab), which is similar to the previous quarter, and which has led to plans for surveys/monitoring exercises and consideration of changes to these rotas.

There were 8 fines issued during this quarter. These were across several rotas, both higher and core trainees and as in the last quarter represent busy shifts when the doctors stayed late to complete tasks or were not able to get adequate rest on non-resident on-call rotas. I therefore do not think that this represents a particular rota or area of concern or risk, but rather more complete reporting of trainees staying late particularly after twilight and long-day shifts. The fine money generated up until the forum in September was discussed with the agreement to share this equitably by trainee numbers to buy pizzas at training events.

The use of the emergency rota and training / back-up rota to cover rota gaps has remained at similar lowered levels this quarter to the previous quarter which is encouraging.

The number of locum shifts covered by trainees (181) is slightly lower than in recent quarters (228 in April-June 2023; 209 in Jan-March 2023; 188 in Sept-Dec 2022). Since the beginning of August 2023, the process of allocating on call shifts to our Teaching Fellows has been changed and the Trust has also employed an innovative clinical fellow whose main purpose is to cover out of hours gaps that arise (this doctor also has a supernumerary day job for when they are not on call/rest days). It is encouraging that these changes are resulting in a positive outcome in terms of the need for locum shifts; this will continue to be monitored.

IR1s are collated by Medical Education staff and the Director of Medical Education (DME) and are reviewed through the GoSW forum. This continues to represent a gradual fall in numbers and reflects improvement in practice; the GoSW has fed back this positive progress to trainees, encouraged doctors to continue this practice which remains a priority for both patient safety and the ward doctors' workload as well checking that trainees new to the Trust are familiar with the process of completing an IR1.

The GoSW forum has continued as a hybrid model since COVID restrictions were eased and plans to continue to run this way making it more accessible for all trainees to attend.

3. Recommendation/summary

Work continues to increase the completeness of Exception Reporting and change the culture of under-reporting. Trainees are encouraged to complete an exception report as necessary.

We will continue to encourage trainees to report episodes of Insufficient Medical Handover and promote good practice and feedback progress to clinicians throughout the Trust.

The Board is asked to receive the report for information/assurance.

Dr Clare McLeod
Guardian of Safe Working

Dr Rajesh Nadkarni
Executive Medical Director

5 October 2023

16. RAISING CONCERNS - WHISTLEBLOWING REPORT

Lynne Shaw, Executive Director of Workforce and OD

REFERENCES

Only PDFs are attached

16.1 Raising Concerns & Whistleblowing Report - Apr-Sept 2023.pdf

Name of Meeting	**Trust Board**
Date of Meeting	**1 November 2023**
Title of Report	**Raising Concerns/Whistleblowing Report – April-September 2023**
Executive Lead	**Lynne Shaw, Executive Director of Workforce and OD**
Report author	**Michelle Evans, Deputy Director of Workforce and OD**

Purpose of the report	
To note	
For assurance	**X**
For discussion	**X**
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	
2. Person-led care, when and where it is needed	
3. A great place to work	**X**
4. Sustainable for the long term, innovating every day	
5. Working with and for our communities	

Meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
People Committee	**X**
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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

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

Trust Board
Wednesday 1 November 2023

Raising Concerns/Whistleblowing Report

1. Executive Summary

The purpose of this paper is to provide a summary of whistleblowing cases/concerns raised over the period from 1 April 2023 to 30 September 2023.

The paper aims to give an overview of cases reported centrally to the Workforce Team in line with the Trust's Raising Concerns Policy. Concerns raised with the Freedom to Speak Up Guardian (FTSUG) are also included. Additional concerns are raised and dealt with informally at a local level by operational managers and these concerns are not logged centrally.

In Sir Robert Francis' Freedom to Speak Up review it stated that not all concerns raised become subject to formal investigation under Raising Concerns or Grievance Policies. This is an approach welcomed and adopted by the Trust.

During the period identified, 46 issues have been raised either centrally or with the FTSUG. This is an increase of 5 compared to the previous period. Out of the 46 concerns raised, five have been categorised as 'whistleblowing'. 37 concerns were raised to the FTSUG and 9 were raised centrally, 8 of which came via the CQC.

There has been a decrease in concerns linked to patient safety but an increase in cases linked to Bullying and Harassment, in particular linked to a protected characteristic.

2. Risks and mitigations associated with the report

The Trust ensures all concerns raised are reviewed robustly and where required undertakes formal investigations.

3. Summary

The Trust has had for a number of years a clear, defined process for recording cases that fall under the scope of a policy such as whistleblowing (raising concerns), disciplinary or grievance, however, there are a number of concerns raised which do not meet the Disclosure Act's definition of whistleblowing. In these instances, the Trust has developed a separate recording category called "raising concerns" for reporting purposes.

The concerns raised have emerged from different routes both internally and externally. It is anticipated that a greater number of concerns will continue to have been raised over the same period of time and have been dealt with locally at ward/department level. In addition, concerns which have been raised through the disciplinary and grievance procedures are also not included within this report. This is to be encouraged but also balanced against a wider desire to understand better any themes or trends.

Themes

Summary of Cases Logged Centrally and with FTSUG 1 April 2023 – 30 September 2023

Type of Case	Concern	Whistleblowing
Values and Attitude	10	0
Policies and procedures	11	0
Safety	7	5
Bullying and Harassment	4	0
Bullying and Harassment linked to protected characteristic	6	0
Unknown	3	0
TOTAL	41	5

Policy and Procedures

The main themes from raising concerns during this period are predominantly linked to the application of workforce policies and procedures. A number are linked to employee relations processes, as well as concerns linked to rotas, roles and responsibilities, supervision and move of employee base.

The Trust has changed its approach to triaging employee relations cases and as such the number of cases is reducing and time taking for fact finds and triage is reducing. This new process is still being embedded and there are still several outstanding legacy cases.

Managers are being asked to prioritise employee relations cases in their day-to-day workload. The Trust also ensures cultural ambassadors are involved in cases where appropriate. The other concerns linked to policy and procedures have been able to be resolved at a local level and ineffective communication has been a key issue.

Values and Attitudes

The Guardians have identified the need for improved communications between managers and staff. Often staff raise concerns which would not have arisen had effective and appropriate communication taken place in the first instance. Whilst ineffective communication is a key factor in the values and attitudes theme, it spans across most of the concerns raised. The Guardians have recommended the Trust considers reviewing how we can improve the ‘soft skills’ of managers, including the need to be able to communicate effectively and have difficult conversations. The Trust will continue to roll out its respectful resolution programme across the organisation as well as manager skills training and the collective leadership programme.

All managers at Bands 8a and above will now receive a copy of the NHS Managers Code of Conduct and this will be included as a contractual requirement for all new managers.

Bullying and Harassment

This report has separated out bullying and harassment linked to protected characteristics as we have seen an increase in concerns raised about inappropriate behaviours where the person feels this is due to their protected characteristic.

The Trust has been undertaking more training and awareness regarding protected characteristics. The incident reporting system has been updated to allow people who experience hate crime from either other staff or patients to report it. As part of Disability Awareness Month, the Trust also undertook awareness training facilitated by the disability awareness charity Purple. As part of Black History Month, the Trust also launched its See Me First campaign where staff agree to be active allies standing up against any unfair treatment or discrimination they see. The North locality has launched a Cultural Allies pilot and if successful this will continue to be rolled out across the organisation.

Safety

The concerns raised regarding patient safety have predominantly been received via the CQC and link to individual patient cases or concerns regarding the professional conduct of staff. All cases were investigated and a full response provided to the CQC.

There have been 3 concerns linked to staff safety and these have all been addressed on an individual basis.

The Trust continues to support the use of body warn cameras as well as CCTV. In addition the Trust is reviewing the use of lone worker devices.

Areas where concerns have been raised

Locality	Number of concerns raised
Central Locality	19
North Locality	12
Unknown/Not Specified	7
North Cumbria Locality	3
South Locality	3
Corporate	2
TOTAL	**46**

Service area	**Number of concerns raised**
Inpatients	18
Community	16
Service area not specified	12
TOTAL	**46**

Historically, it has been predominantly inpatient areas where the most concerns have been raised. Whilst this remains the case for concerns raised via the CQC, there has been an increase in staff in community services raising concerns. There was also an increase in staff wishing not to disclose their service area or not providing additional information to enable the Guardians to provide support.

The Central locality in both inpatients and community is the area with the most concerns raised and North Cumbria and the South localities the least. The Central locality has seen an

increase in concerns raised in the community services but the Guardians feel this is because the staff in those areas have worked with the Guardians for a number of years and feel comfortable approaching them.

Role of Guardians

The Guardians have been able to support more staff to resolve issues themselves without the Guardians having to escalate the issue. This may be through encouraging conversations to take place with managers, signposting staff to utilise existing processes and support mechanisms available or providing some confidence and reassurance to staff. The Trust will work with the Guardians to undertake further communications and awareness with staff of where they can access these processes and support. A new process has been developed with the Guardians to ensure they have a direct route to escalate cases as and when required. There have also been ongoing discussions with Staff Side to ensure they work effectively together and ensuring there is no duplication and cross over of roles which may result in something being missed when one believes the other is supporting.

Communications is ongoing to raise the profile of the two FTSUGs and they are working with the FTSU Champions to ensure staff across the Trust are able to access support and understand where they can raise concerns.

Feedback from the Guardians is that there remains a feeling that some staff will not raise concerns for fear of repercussions or staff have apathy at raising a concern feeling nothing will be done. Further work will be undertaken with the Guardians to raise awareness and improve psychological safety for those staff who wish to raise concerns. The executive management team has sent out communications in the wake of the Letby case to encourage staff to raise concerns and the importance of speaking up. There will also be a message going onto ESR and Payslips in the coming months.

There are 18 cases which remain open for the period, all of which are being overseen by the FTSUGs. The majority of these cases have had local actions undertaken to resolve the issues but the Guardians have chosen to monitor the outcome of the local actions. There are also a couple of cases which remain open whilst investigations are ongoing.

The number of cases raised remains to be of an average number for a Trust of this size. The FTSUGs have been allocated 19.5 hours per week to dedicate to working on FTSU activity including supporting staff and raising the profile of the role. There are ongoing regular meetings with the FTSUGs and the Executive Director of Workforce and Organisational Development to discuss themes and agree actions to resolve.

Michelle Evans
Deputy Director Workforce & OD

Lynne Shaw
Executive Director Workforce & OD

13 October 2023

16.1 FREEDOM TO SPEAK UP REFLECTION TOOL AND ACTION PLAN

Lynne Shaw, Executive Director of Workforce and OD

REFERENCES

Only PDFs are attached

16.2 Freedom to Speak up Reflection and Planning Tool.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Name of Meeting	**Trust Board**
Date of Meeting	**1 November 2023**
Title of Report	**Freedom to Speak up – Reflection and Planning Tool**
Executive Lead	**Lynne Shaw, Executive Director of Workforce and OD**
Report Author	**Lynne Shaw, Executive Director of Workforce and OD**

Purpose of the report	
To note	
For assurance	**X**
For discussion	**X**
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	**X**
2. Person-led care, when and where it is needed	
3. A great place to work	**X**
4. Sustainable for the long term, innovating every day	
5. Working with and for our communities	

Meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
People Committee	**X**
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	**X**
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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

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

Trust Board
Wednesday 1 November 2023

Freedom to Speak up Reflection and Planning Tool

1. Executive Summary

The National Guardian's Office has produced an improvement tool to assist organisations to identify strengths and gaps across individuals, leadership teams and organisations in terms of Freedom to Speak Up.

The attached self-assessment has been completed with support from the Non-Executive Director with responsibility for FTSU, former and current FTSU Guardians and highlights areas of good practice and gaps that need further consideration.

Trusts were advised that not all areas were relevant at a particular point in time but a decision was made to assess against all areas to identify further work to address the gaps. All actions have been given a deadline of March 2024 or earlier to ensure the Trust's approach to speaking up is strengthened at the earliest opportunity.

2. Risks and mitigations associated with the report

N/A

3. Recommendation

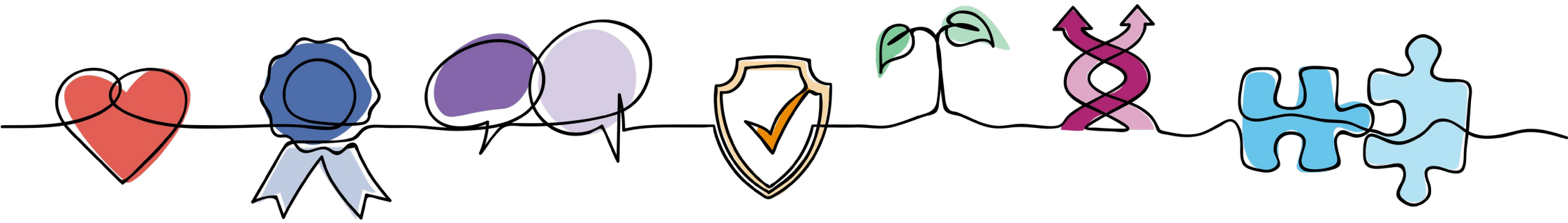
The Board is asked to note the content of the paper and receive assurance on the current Freedom to Speak Up arrangements across

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

Enter summarised commentary to support your score.

The Executive Director of Workforce is the senior lead responsible for FTSU and has been involved in all stages of its inception and development.

Initially the arrangements were not formally reviewed but incrementally reviewed as issues/developments arose locally/nationally. The arrangements were formally reviewed in 2022 and will be carried out every two years thereafter.

At the end of 2022 the FTSU Guardian stood down and two others appointed through expressions of interest. One was a three year tenure, the other a two year tenure. Moving forward the tenure will be two years for all Guardians taking up the role. Each Guardian was given one day a week to undertake the role. This was reviewed after three months in post and an additional 4.5 hours was allocated. This will be further reviewed as necessary.

The Executive Director of Workforce is briefed by the Guardian every month and is available for additional support as required. In addition the Deputy Director of Workforce and OD supports the Guardians as necessary.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. N/A

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I am confident that the board displays behaviours that help, rather than hinder, speaking up	Yes
I effectively monitor progress in board-level engagement with the speaking-up agenda	Yes
I challenge the board to develop and improve its speaking-up arrangements	Yes
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am involved in overseeing investigations that relate to the board	N/A
I provide effective support to our guardian(s)	Yes

Enter summarised evidence to support your score.

The NED lead for FTSU meets with the Guardians every 6 weeks and receive updates on issues/complaints that have been reported. Emergent themes are reviewed as well as the Guardians views on how concerns or complaints have been acted upon and whether the support they receive is adequate to fulfil their role.

The NED lead for FTSU also chairs the Trust's People Committee. This a formal committee of the Board. The FTSUGs attend alternate meetings as a standing agenda item, where they can report back on their work over that period. The NED lead for FTSU has good access to, and regular contact with, the Executive Director of Workforce and OD where any specific issues can be raised. The process, relationships and reporting to date are deemed to have worked well from the NED lead perspective.

Whilst there have been no investigations that relate to the Board, the NED lead would provide oversight of any concerns raised.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. N/A

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	5
We regularly and clearly articulate our vision for speaking up	5
We can evidence how we demonstrate that we welcome speaking up	4
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	4
We regular discuss speaking-up matters in detail	4

Enter summarised evidence to support your score.

Raising Concerns/Whistleblowing cases are discussed bi-annually through Executive Management Team, People Committee and Board of Director Meetings. Cases and themes are now discussed monthly at Business Delivery Group – Workforce.

FTSU Guardians attend the People Committee bi-annually and the Audit Committee annually (as necessary). They have also attended Trust Board.

Speaking up is specifically articulated in our Trust strategy which was ratified by Trust Board in April 2023.

There are posters throughout all wards and departments to identify the FTSU Guardian and their contact details.

There is communication about the role and speaking up in the Trust Bulletin which highlights that there will be no detriment to staff for speaking up. This has been further articulated by other means such as the Exec Q&A sessions.

The staff survey results are one indicator used to understand the feedback from staff that leaders role-model behaviours that encourage people to speak up.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1. Review processes for identifying and addressing detriment.

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes

Enter summarised evidence to support your score.

Speaking up culture is discussed in leadership programmes, management skills programmes and Trust induction.

Current disciplinary and grievance policies and processes are being reviewed in line with a Just and Restorative Culture approach. Linked to PSIRF work which has commenced across the Trust.

FTSU Guardians are linked into staff networks and work closely with trade unions colleagues.

FTSU intelligence is discussed at regular meetings with Executive Director of Workforce and OD and Non-Executive Director with responsibility for speaking up. Data is discussed monthly at Business Delivery Group – Workforce and bi-annually at the People Committee with the FTSU Guardians in attendance.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review OD plans in relation to speaking up as part of transformation programmes.

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	4
We have reviewed the ringfenced time our Guardian has in light of any significant events [illegible] recruiting guardians	4

Enter summarised evidence to support your score.

Ring-fenced time for FTSU Guardians was discussed between Executive Directors prior to advertising the role and in discussions with feedback from the previous FTSU Guardian.

Two FTSU Guardians are in post. Initially each had ring-fenced time of 7.5 hours. This was increased to 12 hours for one of the FTSU Guardians following a 3 month review. Guardians are aware that this time will be further reviewed as necessary.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. N/A

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	4

Enter summarised evidence to support your score.

The Trust's Speaking Up policy entirely reflects the National Guardian's Office speaking up policy. This has been communicated in the Trust Bulletin and on the intranet.

Staff survey results indicate that staff know how to find the speaking up policy, however, more can always be done to raise the awareness of the policy.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. N/A

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	5
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

The appointment of the FSTU Guardians was communicate in the Trust Bulletin and there is a communications plan with regular slots identified throughout the year to publicise the Guardians and the work that they do.

The Trust intranet site has a section for Freedom to Speak Up which includes details of the policy, how to speak up and who the FTSU Guardians and Champions are.

We currently do not communicate positive stories about speaking up to the Trust as a whole, though it forms part of the FTSU Champions' training.

We do not routinely measure the effectiveness of the communications strategy for FTSU, however, the National NHS Staff Survey is a good indicator of whether staff know how to raise concerns.

We are shortly to reintroduce Learning and Improvement Webinars and consideration to be given to how FTSU can be included, particular in terms of positive stories or learning

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Consider how learning can be shared in terms of positive speaking up stories.
2. Review the communications strategy with the FTSU Guardians.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	2
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	5
Our HR and OD teams measure the impact of speaking-up training	3

Enter summarised evidence to support your score.

Training is widely available for staff and advertised via the Academy and Bulletin. There are no current plans to mandate the training for staff.

FTSU face to face training is delivered by the Freedom to Speak up Guardians.

All FTSU Champions undertake training.

Freedom to Speak up features in both corporate induction and local induction as well as the Trust Leadership and Management Skills programmes.

The impact of speaking up training is not measured, however feedback from staff and results of the staff survey linked to speaking up are considered at both a Trust and a local level.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review the training offer for staff.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	4
All managers and senior leaders have received training on Freedom to Speak Up	2
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2

Enter summarised evidence to support your score.

The new FTSU policy has been ratified and communicated via the Trust Bulletin and intranet.

FTSU training has been encouraged as part of the launch of the new policy.

The majority of concerns are low level and are dealt with by managers on a day to day basis: speaking up is seen as part of normal practice. More significant concerns are co-ordinated via Capsticks HR Advisory service or via the FTSU Guardians.

There is evidence that some staff are still afraid to speak up, and we are continuing to work on culture change with respect to this. The FTSU Guardian has worked with the EDI officers to particularly encourage those whose ability to speak up appears to be diminished due to a protected characteristic or their ethnicity/culture.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review the training offer for staff.

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	4
We use triangulated data to inform our overall cultural and safety improvement programmes	4

Enter summarised evidence to support your score.

The FTSU Guardians are supported to identify potential areas of concern and follow up on them. This can be demonstrated via meetings/e-mails from the Guardian to local line managers, CBU/Group level or with Executive Directors and in the bi-annual reports through the People Committee and Trust Board.

Data is triangulated with other metrics such as incidents, disciplinaries, grievances, absences, turnover and patient safety / Patient Advice and Liaison Service data to understand overall culture and safety in specific areas.

Learning and Improvement Webinars are shortly to be re-introduced and learning/positive stories from FTSU will be included as appropriate.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Consider how learning can be shared in terms of positive speaking up stories.

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	3
We share the good practice we have generated both internally and externally to enable others to learn	4

Enter summarised evidence to support your score.

Work currently underway to review reports from other organisations to identify good practice.

FTSU Guardians network nationally and regionally and discuss best practice and lessons to be learned cross-organisationally.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. FTSU Guardians to link in with other regional and national Guardians to ensure that best practice can be learned.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5

Enter summarised evidence to support your score.

The Trust FTSU Guardians were appointed through a Trustwide expressions of interest. They were interviewed by a panel consisting of the Chief Executive Officer, Executive Director of Workforce and OD and the Non-Executive Director with FTSU responsibilities.

Both Guardians have been trained and registered with the NGO.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	2
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	4
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

There are no specific performance and development objectives in place currently though the previous Guardian had an annual objective related to his work in his annual appraisal and agreed with his line manager.

The Guardians receive support from the Executive Director of Workforce on a monthly basis.

There is additional support from the Non-Executive Director with responsibility for FTSU.

Guardians have access to emotional support / supervision and also peer support from each other.

Regional and National FTSU networks provide peer guidance and support to each other.

Now that we have appointed two Guardians, the problem of absence cover for our formerly sole Guardian has been resolved.

Guardians provide the necessary data quarterly to the NGO.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Consideration to be given to setting specific performance and development objectives for FTSU Guardians.

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	5
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
We are assured that confidentiality is maintained effectively	4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	3
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	3

Enter summarised evidence to support your score.

Managers are trained in the application of cases via the Trust's Management Development programme.

Confidentiality is maintained if requested.

We are assured that local low level concerns are progressed in a timely manner within teams or directorates. Cases raised via the FTSU Guardians or via other routes can experience delays depending on the complexity of the issues raised. Timescales are monitored by the FTSU Guardians who would escalate delays to the Executive Director of Workforce and OD as appropriate.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. N/A

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	3
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	5
We have evaluated the impact of actions taken to reduce barriers?	3

Enter summarised evidence to support your score.

The Trust has two FTSU Guardians who have been in post for several months. This followed an extensive handover from the outgoing Guardian who supported the individuals to understand the role, reporting arrangements etc. The Guardians have completed the National Guardians office training and we are confident they understand their role.

The majority of concerns are low level and are dealt with by managers on a day to day basis: speaking up is seen as part of normal practice.

There is evidence that some staff are still afraid to speak up, and we are continuing to work on culture change with respect to this. Work has been undertaken by the FTSU Guardian and the EDI Lead to particularly encourage those whose ability to speak up appears to be diminished due to a protected characteristic or their ethnicity/culture.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Explore reasons why there are barriers to raising concerns with the FTSU Guardians and agree what actions need to be undertaken.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	2
We monitor whether workers feel they have suffered detriment after they have spoken up	2
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	2

Enter summarised evidence to support your score.

Currently the FTSU Guardians determine what they consider to be detriment, undertake monitoring, and report that in the quarterly data. There is still some work to be done by the board to explore their role in this process.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. FTSU Guardians to develop processes to review instances where a worker has felt they have suffered detriment.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	3
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	5
Our improvement plan is up to date and on track	2
Enter summarised evidence to support your score. There have been two external audits of the FTSU process in the past seven years. We learned from each and improved our processes. An appropriate time to undertake another audit would be after the new Guardians have been in post for a year.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1. Review current FTSU processes to ensure they are still relevant and fit for purpose.	

Statements about evaluating speaking-up arrangements	Score 1–5 or

	yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	3
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	2
Our speaking-up arrangements have been evaluated within the last two years	5
Enter summarised evidence to support your score. We have introduced two new Guardians as part of the evaluation of speaking-up arrangements. We have determined that their appointments will be time-limited, in order to keep a fresh pair of eyes on our arrangements.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1. Review processes in line with above.	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
We have we evaluated the content of our guardian report against the suggestions in the guide	3
Our guardian(s) provides us with a report in person at least twice a year	4
We receive a variety of assurance that relates to speaking up	5
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3
Enter summarised evidence to support your score.	

Raising Concerns/Whistleblowing reports are currently being reviewed. In addition to the bi-annual report which is discussed at Executive Management Group, People Committee and Trust Board, a more detailed monthly report is being discussed at Business Delivery Group – Workforce on a monthly basis and triangulated with other metrics as required.

FTSU Guardians attend the People Committee bi-annually and the Audit Committee annually (if required).

Learning and improvement from cases to be shared as part of the Learning and Improvement Webinars as necessary.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Review processes for identifying and addressing detriment	March 2024	Exec Director of WoD / FTSUGs
2. Review OD plans in relation to speaking up as part of transformation programmes	March 2024	Assoc Director of OD / Head of Workforce Developments
3. Consider how learning can be shared in terms of positive speaking up stories	January 2024	Deputy Director of WoD / FTSUGs
4. Review the communications strategy with the FTSU Guardians	November 2024	Exec Director of WoD / Director of Comms / FTSUGs
5. Review the training offer for staff	January 2024	Exec Director of WoD
6. FTSU Guardians to link in with other regional and national Guardians to ensure that best practice can be learned	November 2024	FTSUGs
7. Consideration to be given to setting specific performance objectives for FTSUG	January 2024	Exec Director of WoD
8. Further explore reasons why there are barriers to raising concerns	January 2024	Exec Director of WoD / FTSUGs
9. Review current FTSU processes to ensure they are still relevant and fit for purpose	January 2024	FTSUGs

17. INTERNATIONAL RECRUITMENT UPDATE

Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance

REFERENCES

Only PDFs are attached

17. Pause in recruitment of IENs Board (002).pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1 November 2023**
Title of report	**Review of the Trust position with respect to the recruitment and development of Internationally Educated Nurses**
Executive Lead	**Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance**
Report author	**Liz Hanley, Associate Director Nursing and Quality; Anne-Marie Lamb, International Partnerships Matron**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	
2. Person-led care, when and where it is needed	
3. A great place to work	✓
4. Sustainable for the long term, innovating every day	
5. Working with and for our communities	

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

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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
None identified.

Report to the Board of Directors

Wednesday 1 November 2023

Review of the Trust position with respect to the recruitment and development of Internationally Educated Nurses

Executive Summary

Due to a number of key operational and professional issues over recent months a decision has been made to pause recruitment of Internationally Educated Nurses (IENs) from 14.9.23 until the end of the financial year 2023/24. This pause provides an opportunity to undertake a comprehensive review of all standard processes, alongside a review of workforce plans and financial forecasts relating to the recruitment of all Internationally Educated Professionals. This includes reviewing the relocation package and the related policy and employment contracts. Information relating to relocation packages provided by Trusts throughout the UK will be drawn upon to complete this review.

Introduction and background

The NHS has always benefited from overseas recruitment, recruiting nurses, doctors and Allied Health Professionals (AHPs) from other countries to live and work in the UK. Recruitment from outside the UK continues to feature as an important part of the workforce supply strategy of NHS organisations in line with the NHS people plan (https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/).

The NHS Long Term Plan also identifies ethical international recruitment as a workforce priority (https://www.longtermplan.nhs.uk/) and the strict ethical standards for international recruitment are detailed in the DHSC Code of Practice for the International Recruitment of Health and Social Care Personnel in England (https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england).

Although a high number of Internationally Educated Nurses apply to work in CNTW, the numbers recruited are relatively very low, for example, circa 300 applicants received following the recruitment completed in August 2023, resulted in 2 nurses being appointed.

CNTW recruitment of IENs

The market is now more competitive than previously, with several NHS organisations recruiting from the same market.

A higher level of support and supervision is required for at least the first year to enable the nurses to adjust to their new life in the UK, including fostering the appreciation of cultural differences and new ways of working in a different clinical

environment. This needs to be considered within local workforce plans when identifying vacant posts.

The Objective Structured Clinical Examination (OSCE) program for the nurses has been a great success, with a 93+% pass rate to date (this includes passing within two attempts). All Internationally Educated Nurses initially start with the Trust as a band 3 Healthcare Support Worker. The intensive support within the first 6 - 8 months and the development of OSCE suite have been factors in the success of the programme.

The nurses undergo an 8–12-week programme, starting with a 5-day induction with the IRRS team, followed by the Trust corporate induction, before starting with the clinical teams. They are supported by IRRS and the clinical nurse educator in the lead up to the exam. An accelerated programme was developed which allows the intense teaching to be delivered over a 2-week period. There is time to put the theory into practice within clinical roles and supported studying opportunities. There is follow up intensive practice and mock exams over the 2 weeks prior to the exam.

Following successfully passing the OSCE and receiving their Nursing and Midwifery Council (NMC) PIN, they commence as a band 5 registered nurse. The nurses are then supported to complete the 12-month accredited preceptorship programme.

Relocation and Pastoral Support

As part of core business, the International Recruitment Relocation and Support team is committed to providing excellent levels of pastoral support to newly recruited internationally educated staff. This ensures a smooth start to life in the UK, a warm welcome to CNTW, and helping new staff and their families in a multitude of ways outlined below. CNTW has been successful in achieving the NHS Pastoral care Quality Award and is committed to the ongoing pastoral support of internationally educated nurses, doctors and Allied Health Professionals.

Early on boarding is essential to make the journey as stress free as possible for the new nurse. Transport is organised to collect the nurse from the airport and take them to their new home, where one of the team meets the new nurse and orientates them to the property and the local area. Each person is part of a cohort induction and is supported into their new clinical team.

Development of IENs working in CNTW

The opportunities for IENs to develop and be considered for more senior clinical and leadership roles are in development, supported by the Accelerated Development Programme, which was funded as a collaboration with North Cumbria Integrated Care Trust.

There are also pilot projects in progress to evaluate the IEN adult nurse focus on physical health monitoring and support and a pathway is proposed to enable IEN adult nurses to work towards registration as mental health nurses with the NMC.

Internationally Educated Nurse arrivals to date

The number of Internationally Educated Nurses has risen significantly over the last few years. This led to the program deploying a dedicated staff group to support the

recruitment process, relocation and pastoral support, and a clinical nurse educator to support the knowledge and skill development requirements leading to the success in completing the OSCE.

Year	Nurse Arrivals to CNTW	Nurses left CNTW	Reason for leaving
2017	1		
2018	7		
2019	1		
2020	10		
2021	15	2	Relocated to Canada Moved to Acute Trust
2022	40	1	Relocated to USA,
2023	51	1	Failed OSCE & probation
2023 in process	2		
TOTAL	**127**	**4**	**123**

Recruitment trajectory:
An additional 2 nurses in the processes of relocating and have posts identified.

Impact of the pause to nurse recruitment:

Risks

Financial
The main identified risk of pausing the nurse recruitment is the risk of current and future funding from NHS England. The agreement with NHSE for 20 nurses with the winter preparedness fund is in deficit by 15 nurses to the value of £150,000. The return of this finance may be requested and distributed to other Trusts that have excelled with nurse recruitment.

Future funding projects would also be at risk, such as the new project to provide £12,000 funding per recruited internationally educated nurse, where the nurses are engaged in a training programme prior to travelling to the UK.

Recommendations
It is recommended that the Board notes the pause in recruitment of Internationally Educated Nurses to enable a review of the related processes and development of a plan to enhance leadership opportunities for IENs, to complement Locality workforce plans.

Anne-Marie Lamb
International Partnerships Matron

Liz Hanley
Associate Director Nursing and Quality

Sarah Rushbrooke
Executive Director Nursing, Therapies and Quality Assurance

18. NHS E/I SINGLE OVERSIGHT FRAMEWORK

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

18. NHS Improvement System Oversight Framework - Quarter 2 2023-24.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**Quarter 2 update - NHS Improvement System Oversight Framework**
Executive Lead	**Ramona Duguid, Chief Operating Officer**
Report author	**Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance** **Chris Cressey, Deputy Director of Finance & Business Development**

Purpose of the report	
To note	
For assurance	**X**
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

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

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience	X	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Quality care, every day – We want to deliver expert, compassionate, person-led care **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. (SA1) **SA2** Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals. **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. (SA2) **SA3** A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers. **Risks 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. (SA3) **SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled**.** **Risk 1762** Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments. (SA4)

Wednesday 1st November 2023

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 2 2023-24

BACKGROUND

NHS Improvement using the System Oversight Framework have assessed the Trust for Quarter 2 of 2023-24 as segment 1 – maximum autonomy. At Month 6 the Trust has agreed with the Trust Board and ICS that financial outturn for the financial year is too breakeven.

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 – Q4 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 6 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): -

	Month 6		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**

I&E – Surplus /(Deficit)	(£5.7m)	(£5.5m)	(£0.2m)
Agency Spend	£8.4m	£9.0m	£0.6m
Cash	£20.7m	£34.2m	(£13.5m)
Capital Spend	£5.0m	£3.3m	£1.7m

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 2 2023-24. Workforce returns are submitted to NHSI monthly.

Summary Staff WTE	**July**	**Aug**	**Sept**
	Actual WTE	**Actual WTE**	**Actual WTE**
Non-medical Clinical	5,496.17	5,505.03	5,519.83
Non-medical Non-Clinical	2,195.70	2,205.16	2,198.41
Medical & Dental	422.34	448.66	447.69
Total WTE Substantive	**8,114.21**	**8,158.85**	**8,165.93**
Bank	266.71	286.35	306.62
Agency	291.77	295.19	304.71
Total WTE all staff	**8,672.69**	**8,740.39**	**8,777.26**

Agency Information

The Trust must report agency shift numbers to NHS Improvement monthly. The table below shows the number of agency shifts, the number above price cap and the number of off-framework shifts reported during Quarter 2 2023-24. The Trusts level of agency use at Quarter 2 is in breach of the allocated ICB agency cap.

	July			August			September		
	Shifts Filled by Agency	On Framework Above Price Cap	Off Framework	Shifts Filled by Agency	On Framework Above Price Cap	Off Framework	Shifts Filled by Agency	On Framework Above Price Cap	Off Framework
Medical	579	95	20	605	111	24	562	112	24
Nursing	704	403	0	676	462	0	565	449	0
Support to Nursing	3,282	99	0	3,577	0	0	3,361	0	0
Admin	53	0	0	47	0	0	41	0	0
Scientific, Therapeutic & Technical	27	27	0	27	27	0	9	9	0
TOTAL	**4,645**	**624**	**20**	**4,932**	**600**	**24**	**4,538**	**570**	**24**

At the end of September, the Trust was paying 29 medical staff above price caps and 9 of the consultants are being paid over £100 per hour so are separately reported to NHS Improvement.

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 Q2 2023-2024

Board of Directors:

No change

Council of Governors:

Elaine Lynch - Local Authority Governor, Cumberland Council

Outgoing Governors:

Leyton Rahman, Public Governor Northumberland

Present vacancies

Carer – Neuro Disability service
Service User – Learning Disability Service
Service User - CYPS
Service User - Older Peoples Service

Never Events

There were no never events reported in Quarter 2 2023 - 2024 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
Chris Cressey, Deputy Director of Finance & Business Development

October 2023

19. INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance

REFERENCES

Only PDFs are attached

19. IPC BAF report Q2.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 1st November 2023
Title of report	Infection Prevention and Control (IPC) Board Assurance Framework
Executive Lead	Sarah Rushbrooke, Executive Director of Nursing, Therapies & Quality Assurance
Report author	Liz Hanley, Associate Director Nursing & Quality Victoria Hancock, Head of Infection Prevention and Control Samantha Cooke, Deputy Head of Infection Prevention and Control

Purpose of the report	
To note	
For assurance	**For Assurance**
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	
3. A great place to work	
4. Sustainable for the long term, innovating every day	
5. Working with and for our communities	

Meetings where this item has been considered		**Management meetings where this item has been considered**	
Quality and Performance		Executive Team	
Audit		Executive Management Group	
Mental Health Legislation		Business Delivery Group	
Remuneration Committee		Trust Safety Group	
Resource and Business Assurance		Locality Operational Management Group	
Charitable Funds Committee			
People			
CEDAR Programme Board			
Other/external (please specify)			

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	x
Quality, safety and experience	x	Service user, carer and stakeholder involvement	

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

Infection Prevention and Control (IPC) Board Assurance Framework

Report to the Board of Directors meeting

Wednesday 1st November 2023

1. Executive Summary

The National Infection Prevention and Control Board Assurance Framework (BAF), first issued by NHS England (NHSE) in May 2020 and updated in March 2023, is designed to provide an assurance structure for Boards through the demonstration of compliance with ten criteria that are aligned with the evidence-based recommendations of the National Infection Prevention and Control Manual (NIPCM). The aim is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures, with the outcomes providing evidence to support improvement and patient safety.

This report covers Quarter 2 (July to Sept 2023).

2. Healthcare Associated Infections (HCAIs)

There were several COVID-19 outbreaks declared during quarter 2. The prevention and management of HCAIs continues to be an integral element of the activity of the Infection Prevention and Control (IPC) Team, with robust systems in place to support surveillance, monitoring, post-incident reviews (PIRs), and root cause analysis (RCA) of incidents.

3. COVID-19

During Quarter 2, there were five COVID-19 outbreaks declared.

There were 49 single cases of patients testing positive for COVID-19 as follows:

- North Cumbria Locality: 19
- North Locality: 10
- Central Locality: 6
- South Locality: 15

There have been no changes to testing or self-isolation guidance since the last quarterly report. The current guidance documents and advice has been reiterated through the Trust Bulletin and all-user communications during quarter 2.

4. Winter Vaccination Campaign

Planning commenced for the 2023-2024 winter influenza and COVID-19 vaccination campaign during quarter 2 and the campaign launched on 9th October.

This year, training for vaccinators has been delivered face-to-face following feedback from the previous campaign lessons learnt event. Peer vaccinators will continue to play an important and active role in vaccinating staff and patients. There will also be a small team of roving vaccinators, led by the IPC Team who can offer additional

support to wards and departments, and they will also be providing some drop-in clinics across the Localities.

All CNTW and NTW Solutions staff members are eligible to receive both the influenza and COVID-19 booster vaccines.

Co-administration of both the influenza and COVID-19 booster vaccines is being offered to maximise uptake, ensure we have protection against flu and COVID-19, and maximise protection of those most at risk in a timely way.

The communications team has a robust communications plan in place and will continue to support with campaign promotion and advertising the planned drop-in clinics.

An internal system for self-declaration has been developed which will enable staff to record vaccines received outside of the Trust for data collection purposes.

The first week of the vaccination campaign has been successful and over 1000 vaccines were administered during this time.

5. IPC Web-based Incident Reports

In Quarter 2, there was a total of **143** Safeguard IPC Incident reports submitted. This is a 14% increase compared to the previous Quarter.

Table 1. Number of incidents reported via locality.

Locality	Number of incidents reported through Safeguard
NTW Solutions	1
Cumbria	20
North	32
Central	41
South	49

IPC Incidents reported included inoculation injuries, water safety issues, new infections (including urinary tract and chest infections) and environmental issues. The IPC team continues to investigate reported incidents and provide advice and support where required.

6. Inoculation and Sharps Injuries

There were 70 inoculation injury incidents reported through the Safeguard reporting system during Quarter 2. This included staff injury due to biting, scratching, and spitting by patients, patient-to-patient assaults, and needlestick incidents. All reported incidents were actively followed up by the IPC Team with training, education and specialist support being provided where required.

Table 2. Inoculation incidents reported via locality.

Locality	Bite	Scratch	Spitting	Exposure through blood	Nipping	Needlestick
Central	3	1	0	0	0	0
Cumbria	6	2	5	0	0	0
North	10	10	10	1	4	0
South	1	2	7	1	0	5
NTW Solutions	0	0	2	0	0	0
Total	**20**	**15**	**24**	**2**	**4**	**5**

7. Compliance with IPC Standards

Trust level compliance is monitored through the IPC assurance audits and reported at the IPC assurance meeting. The IPC team continued to provide education to staff and raise awareness about topical IPC issues.

The IPC Team ensured that where necessary:

- All relevant IPC measures were in place and standard precautions were being adhered to.
- Personal Protective Equipment (PPE) stock was readily available where required.
- All staff who were caring for COVID-positive patients were fit-tested for a Filtering Face Piece (FFP3) mask.

8. Additional Assurance Mechanisms

- Bi-monthly Trust-wide IPC Assurance meetings were held during Quarter 2, and the Trust IPC Committee met on 13th September 2023.
- The IPC Team was (and continues to be) involved in peer visits across other organisations to improve partnership working, share good practice and provide mutual support.
- The IPC team continued to undertake scheduled and as required meetings with Clinical Nurse Managers, Ward Managers and Clinical Care Groups to discuss complex cases, clusters of infection, and outbreak management. Support and guidance was offered for the practical application of the self-isolation of patients and specialist advice provided relating to ending patient isolation from a clinical perspective.
- The IPC team provided comprehensive support and advice to all outbreak areas to review the appropriate use of Personal Protective Equipment and outbreak control measures, to reduce ongoing transmission.
- Annual IPC Risk Assessments of clinical areas continue, with any actions being identified and followed up as appropriate. During Quarter 2, the following areas were visited:

Table 3. Annual IPC Risk Assessments completed in Quarter 1.

Locality	Ward Name	Date of Audit	Total Compliance Score (%)
Cumbria	Riding	17/08/23	90.09%
South	Clearbrook	26/09/23	95.7%
Central	Willow View	27/09/23	89.5%
South	Aldervale	27/09/23	91.8%
South	Brooke House	27/09/23	90.11%
North	Warkworth	28/09/23	87.4%

- The IPC Team continues with planned awareness sessions in relation to waste disposal, cleaning and decontamination, safe use of sharps and management of inoculation injuries across the Localities.
- Induction sessions for new IPC Link Practitioners are in progress. There are currently 164 members of staff on the IPC Link Practitioner register. All Link Practitioners are trained to deliver hand hygiene training and undertake competency assessments in their areas. A total of 11 Link Practitioners attended bespoke Link Worker sessions in Quarter 2.
- The comprehensive roll out of Fit Testing of FFP3 masks continues to be led by the Trust FFP3 Mask Lead and Trainer, including the refit of new models of mask and fit testing to support Occupational Health referrals, multiple failure referrals and those with work-related difficulties.

9. Conclusion

The Board Assurance framework provides assurance that:

- Any areas of risk are identified, and that corrective action is taken in response.
- National guidance impacting on Infection Prevention and Control standards is proactively reviewed, with action taken to implement changes required across CNTW.
- Continuous surveillance and monitoring to ensure high IPC standards and a proactive approach to prevent the spread of healthcare associated infections (HCAIs).

Infection Prevention and Control
November 2023

20. BOARD ASSURANCE FRAMEWORK 2023

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

20. BAF Risk Exception Report - Q2 23-24 DH.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Name of meeting	Board of Directors Meeting
Date of Meeting	Wednesday 1 November 2023
Title of report	Board Assurance Framework (BAF) Exception Report
Executive Lead	Debbie Henderson, Director of Communications and Corporate Affairs
Report author	Yvonne Newby, Risk Management Lead

Purpose of the report	
To note	√
For assurance	√
For discussion	√
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

Meetings where this item has been considered	
Quality and Performance	X
Audit	X
Mental Health Legislation	X
Remuneration Committee	
Resource and Business Assurance	X
Charitable Funds Committee	
People	X
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

R

eport to the Board of Directors Meeting
Wednesday 1 November 2023

Board Assurance Framework

1. Executive Summary

Understanding, monitoring, and mitigating risks are fundamental tasks in a successful Organisation. They are also seen as a basic aspect of good governance. As such, the Board of Directors must determine the best place for risk management to positioned ensuring effective management and assurance processes are in place.

The Trust Board Assurance Framework identifies the strategic ambitions and principal risks facing the organisation in achieving the strategic ambitions.

2. Key issues, significant risks, and mitigations

As a part of the refinement of the Trust's Risk Registers, systems and processes the Risk Management Lead has reviewed with each of the lead Executive Directors/Director, the existing Board Assurance Framework (BAF) Risk Register 2022/23.

Following the launch of the Trust's 'With You in Mind' Strategy in May 2023, the Director of Communication and Corporate Affairs met with all Board Committee Chairs and Executive Leads to review and refresh the existing Board Assurance Framework. At its meeting held 20th September 2023, the Board of Directors reviewed the new Board Assurance Framework and reviewed the Risk Appetite for the organisation in the context of the current challenges, the implementation of Integrated Care systems/Boards, and associated changes to systemwide governance.

This paper provides:

- A summary/overview of the existing BAF up to and including Q2 2023/24 and a recommendation to close these risks (section 2.0).
- Detail of the new BAF risk register from Q3 2023/24 and a recommendation to endorse these as the new BAF risks (section 3.0).
- A summary of the outcome following review of the new BAF at October meetings of the Board Committees.
- Note the revised Risk Appetite for the organisation as developed by, and endorsed by the Board on 20th September 2023 (appendix 1).

1.0 Board Assurance Framework summary (including risks aligned to the Board Committees)

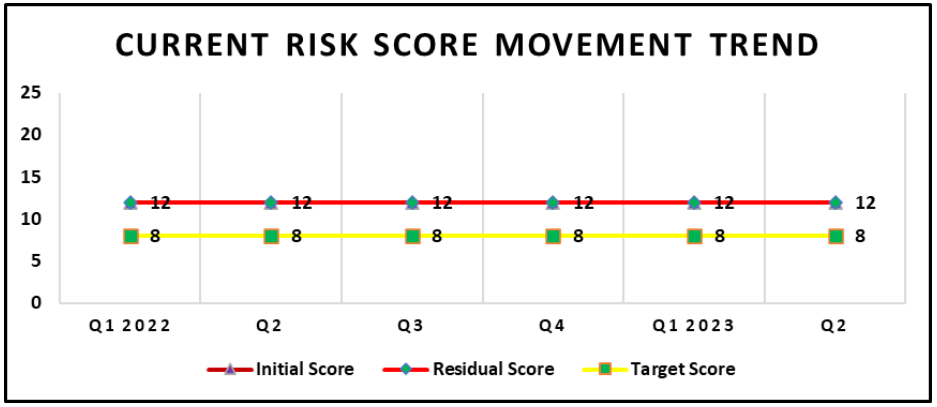
Following discussion at the Board meeting held 20th September 2023, which reviewed the proposed new Board Assurance Framework (BAF), the Committee is asked to consider closure of the existing risks (column A below and section 2.0) in light of the refreshed BAF risks (column B below and Section 3.0). Detail of existing risks and new risks is provided below:

Existing BAF risks (2022/23 – Q2 2023/24) Quality and Performance Committee	New BAF risks (from Q3 2023/24)
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.	BAF Risk 1 – Due to increased demand and capacity the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services. SA1
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.	BAF Risk 1 + BAF Risk 3 – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. SA1
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.	BAF Risk 4 – Failure to deliver our transformation plans around the model of care to address issues relating to community and crisis infrastructures, and demand for inpatient provision which could compromise quality, safety, and experience of service users. SA2
No current risk relating to safety culture	BAF Risk 2 – Risk of failing to maintain a positive safety learning culture resulting in avoidable harm, poor systems, process and policy, and identification of serious issues of concern. SA1
Existing BAF risks (2022/23 – Q2 2023/24) – Resource and Business Assurance Committee	**New BAF risks (from Q3 2023/24)**
1680 – If the Trust were to acquire additional services and geographical areas this could have a detrimental impact on CNTW as an organisation. .	No new risk proposed. Reflected in new BAF Risk 12.
1687 – That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our key programmes.	BAF Risk 8 - Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care. SA4

	BAF Risk 6 - Risk of increased staffing costs from use of temporary staff impacting on quality of care and financial sustainability. SA3
1762 – Restrictions in Capital expenditure due to national limits and the Trusts own cash availability may lead to increasing risk of harm to patients when continuing to use sub optimal environments.	BAF Risk 9 - Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure. SA4
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.	BAF Risk 11- Risk that the Trust does not deliver the objectives of its Green Plan affecting the physical and mental health of current and future generations. SA4
No current risk relating to digital cyber-threat	BAF Risk 10 – Risk that the Trust's information and systems is at higher risk of being compromised leading to unknown vulnerabilities. This could lead to loss and/or public disclosure of information and loss of access to critical systems. SA4
Existing BAF risks (2022/23 – Q2 2023/24) – People Committee	**New BAF risks (from Q3 2023/24)**
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.	BAF Risk 5 – Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3
	BAF Risk 7 - Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up. SA 3
Existing BAF risks (2022/23 – Q2 2023/24) – Provider Collaborative	**New BAF risks (from Q3 2023/24)**
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.	No new BAF risk aligned to this committee. Potential committee-level risks will be considered as part of the ongoing governance review.
Existing BAF risks (2022/23 – Q2 2023/24) – Mental Health Legislation Committee	**New BAF risks (from Q3 2023/24)**
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.	No new BAF risk aligned to this committee. Recognition that the risk, mitigations and actions are delivered at corporate level – risk to be de-escalated to corporate risk register.

Existing BAF risks (2022/23 – Q2 2023/24) – Executive Management Group	New BAF risks (from Q3 2023/24)
No current risks relating to system-wide working.	BAF Risk 12 – If the Trust does not consider its own position as a 'good partner', and the position of others as capable of working in partnership, there is a risk of that the Trust and the system does not allocate resource effectively, in the right place with the right organisations and partnerships which may impact on the ability to deliver high quality, safe services across the system. SA 5

2.0 Existing BAF up to and including Q2 (2023/24)

Date Opened	Risk Description	Risk Appetite – 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)
09/10/2018		
Risks Ref:		
1691 SA1 **MHLC Committee**	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. **SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	
Risk Owner		
Rajesh Nadkarni		

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	3. Possible	4. Major	**12**	Compliance/Regulatory 6-10
Residual Score	3. Possible	4. Major	**12 (Exceeding Appetite)**	Commissioners
Target Score	2. Unlikely	4. Major	8	

Key questions:	Summary of findings		Updated
Have there been any changes to risk?	**Description**	No change to risk description	
	Owner	No change of ownership	
	Is risk to be closed	This risk is to be de-escalated to Corporate Level after going to Board for approval	

		in November.	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	No actions were closed in Q2	
	New Actions Added	No actions were added in Q2	
Action Number	**Action Description**	**Last Action Update**	**Target Date**
5553	Awaiting the Government response to the consultation to then know what changes will take effect within the Mental Health Legislation	In June 2022 the Government published the draft Mental Health Bill, which amends the MHA 1983. However still no update from the Government of when this will be implemented.	31/12/2023
10171	Final Internal Audit report CNTW-2021-22/02 Governance Arrangements LTSP	Plan to report on the LTSP KPIs for Q2 so these should be completed by Oct 2023.	31/12/2023
11836	Improvement review of MHA Training: Q1 - Q4 23/24 Updated figures from Training Dashboard:	Q1 23/24 - 70.3% snapshot Q2 23/24 – 63.1% snapshot	31/12/2023

What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	**Where can we gain assurance that the controls, we are placing reliance on are working**
Working Task Subgroup to monitor remote assessments and support the digitalisation of the MHA	Reported and monitored by IMG and BDG
At a glance boards.	Report will be used to monitor compliance with consent to treatment provisions within part 4a of the MHA.
Internal Audit - CNTW 2022/23 - 26 Mental Health Act - Delegation of Statutory Functions	Final Report - Good Assurance given
Regular review and monitoring of CQC themes raised with Groups at the Mental Health Steering Group and BDG	Mental Health Legislation Steering Group. CQC compliance Group will now review themes and this will be carried out monthly.
Internal Audit - CNTW 22-23 01 Risk Management & BAF	Final report - Good Assurance given

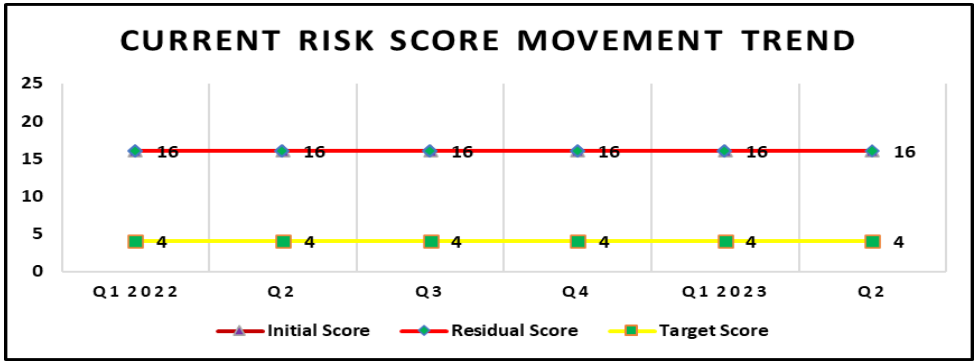
Do all actions have a timescale?	**Were risks reviewed in a timely manner?**	**Expected date risk to be mitigated and brought within the risk category appetite.**
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category

		appetite as soon as practicable. However, this risk will be de-escalated to Corporate level after going to Board for approval in November.

Internal Audit 2022/2023					
Mental Health Legislation Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
Mental Health Legislation Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q2					

Date Opened	**Risk Description**	**Risk Appetite – Quality Effectiveness -** CNTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users. (6-10)
15/03/2018		
Risks Ref:		
1683 SA1 **Q&P Committee**	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands.	

Risk Owner		
Ramona Duguid	**SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	4. Likely	4. Major	**16**	Quality Effectiveness 6-10
Residual Score	4. Likely	4. Major	**16 (Exceeding Appetite)**	Treatment
Target Score	1. Rare	4. Major	4	

Key questions:	Summary of findings		Updated
Have there been any changes to	**Description**	No change to risk description	
	Owner	No change of ownership	
	Is risk to be closed	No	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	No actions completed and closed in Q2	
	New Actions Added	1 new action was added in Q2	30.09.23

Action Number	Action Description	Last Action Update	Target Date
6107	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.	Daily flow meetings in place in each locality. EBM continue with a daily review following locality meetings in order to review capacity. Escalation process in place via AD and Group Director	29/12/2023
8544	Staffing shortages continue to be challenging in key areas, thus impacting on consistent core MDT within ward teams.	Inpatient Staffing workstream continues to develop Model Options. QIA and costings to be completed and presented to Urgent Care Board in October.	29/12/2023

8545	Bed occupancy remains high with significant DTOC in older persons and learning disabilities	Bed occupancy throughout the Trust remains high with a significant number of individuals identified as CRFD particularly within our older persons and learning disabilities wards. In August we appointed 2 part time Senior Case Managers whose port folios include providing support to MDTs on the facilitation of timely discharge from wards. They will also work in collaboration with the Trusts Enhanced Bed Management Service in this area. Our recent work on the 100 Day Challenge highlighted the significance of MADE events to facilitate timely move on however at this point in time we recognise that a lack of social care and be-spoke community options are having a significant impact on our ability to discharge in a timely fashion. We continue to collaborate with the Senior Intervenor in relation to our LD clients but as of yet this has not impacted on discharge rates.	29/12/2023
8546	Crisis team capacity and input to look at overall alternatives to admission	Crisis teams remain under considerable pressure in terms of their ability to undertake timely assessments and ongoing home based treatment due to increased demands as well as extended roles and functions in some areas linked to the management and oversight of 136 suites. This element of the urgent care pathway will require considerable oversight and review to ensure that its role and function aligns with other key initiatives linked to 111 select mental health option and the RCRP. A proposal is currently under development for the more effective management of 136 suite's which may have a positive impact on staff availability and response times for assessments and home based treatment. We continue to work with the ICB Commissioners on the development of appropriate crisis alternatives (crisis houses) and costed models have been developed but as of yet no funding is forth coming. Other support in the form of crisis cafés are being developed however it is unlikely that this will have a significant impact on admission rates.	29/12/2023
8547	Admission and Discharge policy drafted but not yet launched.	Policy has now been formally consulted on. Some changes made and will now go to BDG for final ratification. Aim is to go live from October	29/12/2023
12028	CA-21-0012 - Nutrition policy audit - Moderate areas of concern re Audit is due in Q3 23/24.		29/12/2023

What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	Where can we gain assurance that the controls, we are placing reliance on are working
UEC and IP Programme of work refreshed and updated for 2022/23 deliverables	Monthly updates to BDG

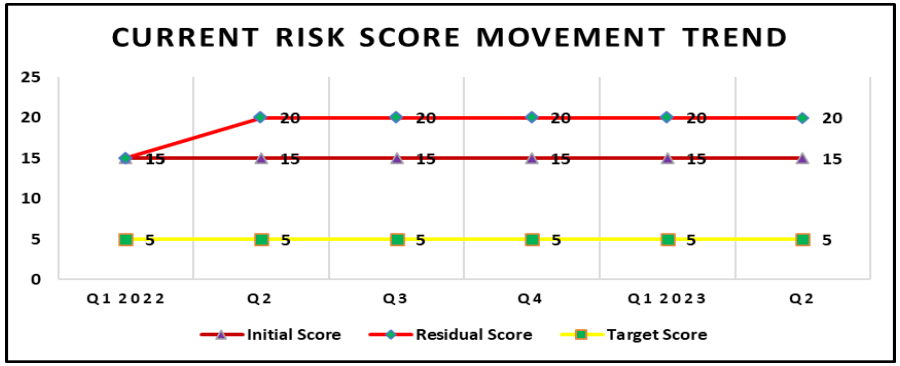
Inpatient essential staffing review commenced.	Report when review completed.
Weekly patient tracker meetings in place	Patient tracker
Weekly DTOC and increased capacity for discharge implemented.	DTOC Report
Internal Audit - CNTW 22-23 01 Risk Management & BAF	Final report - Good Assurance given

Do all actions have a timescale?	Were risks reviewed in a timely manner?	Expected date risk to be mitigated and brought within the risk category appetite.
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable.

Internal Audit 2022/2023					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Must Do- Trust Priority Clinical Audits - Re audit					
CA-21-0012 - Nutrition policy audit - Moderate areas of concern re Audit is due in Q3 23/24.		*			BAF 1683 SA1

Date Opened	Risk Description	Risk Appetite – 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)
15/03/2018		
Risks Ref:		

1688 SA1 **Q&P Committee** **Risk Owner** Ramona Duguid	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. **SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	3. Possible	5. Catastrophic	**15**	Compliance/Regulatory 6-10
Residual Score	4. Likely	5. Catastrophic	**20 (Exceeding Appetite)**	CQC
Target Score	1. Rare	5. Catastrophic	5	

Key questions:	Summary of findings		Updated
Have there been any changes to	**Description**	No change to risk description	
	Owner	No	
	Is risk to be closed	No	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	3 actions were closed in Q2	29/09/2023
	New Actions Added	2 actions were added in Q2	29/09/2023

Action Number	Action Description	Last Action Update	Target Date
8279	CA-21-0001: Allied Health Professional (AHP) Continuing Professional Development (CPD) Audit 2021	Repeat the AHP CPD audit - allowing time for toolkit to be embedded, audit leads to be identified, audit champions group to be reconvened. Propose re-audit in Q3 with support from audit department, analysis and report in Q4. Explore possibility of a PGN re CPD or increasing emphasis in appraisal policy. Ensure CPD is reviewed at appraisal -to be reinforced through comms directly with AHPs and possibly via the Bulletin and assessed through the re-audit.	31/10/2023
10181	CA-21-0038 - The Safe Prescribing of Rapid Tranquilisation (RT)	Report minor areas of concerns - re-audit is due in Q3 24-25. Action plan due at MOC in July.	30/11/2023
10183	CA-22-063.01 Safeguarding Adults	Requesting an extension at CEC for this action.	31/10/2023

	at Risk Final Report - Moderate areas of concern re-audit is due in Q3 23/24		
10184	CA-21-0012 - Nutrition policy audit - moderate areas of concern re-audit is due in Q2 23/24.	Training was paused due to severe staff shortages. Face to face training is now scheduled for July and August. Teams training to begin by September 23.	29/12/2023
11052	CA-21-0032 NICE (Implementation) NG134 Depression in CYPS - Areas of Concern	The sponsor and lead are due to present at each locality QS Meetings over the next month. There are plans to disseminate further, and to set up discussions relating to admin support and advertising the specialist adolescent mood disorders (SAMS). So, whilst only the review has happened as planned, there are plans in place for most of the other actions. The lead and sponsor have been informed of the extension to deadline, which is now 31/07/2023.	31/10/2023
12509	CA-22-039.05 Physical Health Monitoring following Rapid Tranquillisation - High (25) areas of concern so the re-audit is due in Q3 23-24.	Drug list has been put into the Safeguard test system, and are currently testing it, before moving to live.	31/10/2023
12734	CA-21-0014 POMH-UK Topic 1h & 3e Prescribing high dose and combined antipsychotics combined with CA-21-0034 minor areas of concern.		31/07/2024

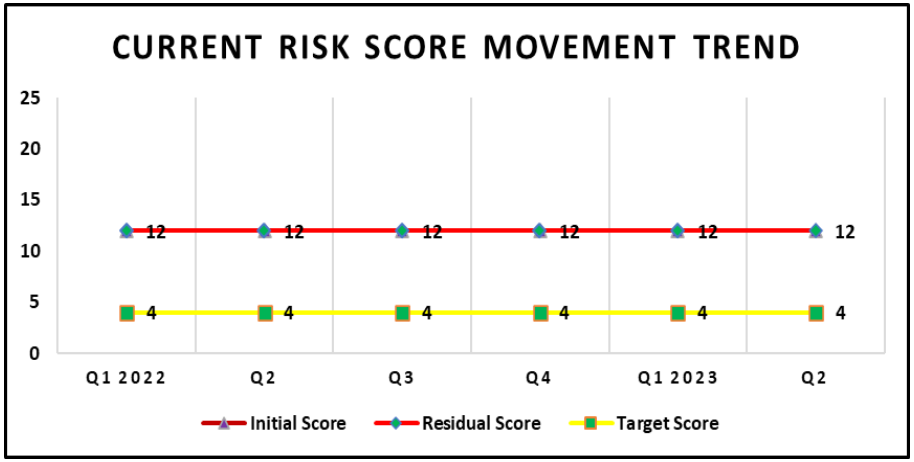
What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	Where can we gain assurance that the controls, we are placing reliance on are working
Integrated Governance Framework	Integrated Governance Framework
Inpatient essential staffing review commenced.	Report when review completed.
Agreement of Quality Priorities	Monitored via reports/updates
Monitored via reports/updates	Copy of recovery Plan
Internal Audit - CNTW 22-23 01 Risk Management & BAF	Final report - Good Assurance given

Do all actions have a timescale?	Were risks reviewed in a timely manner?	Expected date risk to be mitigated and brought within the risk category appetite.
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category

		appetite as soon as practicable.

Internal Audit 2022/2023						
Quality & Performance Committee	**2023/2024**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				All BAF risks	
Internal Audit – CNTW- 22-23 14 Performance Management & reporting – Substantial level of assurance.	*				BAF 1688 SA.1	

Clinical Audit Plan					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Must Do- Trust Priority Clinical Audits - Re audit					
CA-21-0014 POMH-UK Topic 1h & 3e Prescribing high dose and combined antipsychotics combined with CA-21-0034 minor areas of concern		*			BAF 1688 SA.1
CA-22-039.05 Physical Health Monitoring following Rapid Tranquillisation - High (25) areas of concern so the re-audit is due in Q3 23-24.		*			BAF 1688 SA.1
CA-22-011.05 Seclusion Annual Audit - Registered					BAF 1688 SA.1
CA-21-0012 - Nutrition policy audit - Moderate areas of concern re Audit is due in Q3 23/24.		*			BAF 1688 SA.1
Should Do – Trust Priority Clinical Audits – Re audit					
CA-23-001 CPD audit for AHPs (Trustwide)					BAF 1688 SA.1
CA-22-063.01 Safeguarding adults at Risk					BAF 1688 SA.1

Date Opened	Risk Description	Risk Appetite – Quality Effectiveness - CNTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users. (6-10)
01/06/2020		
Risks Ref:		
1836 SA2 **Q&P Committee**	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. **SA2** Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	
Risk Owner Ramona Duguid		

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	3. Possible	4. Major	**12**	Quality Effectiveness 6-10
Residual Score	3. Possible	4. Major	**12 (Exceeding Appetite)**	Services
Target Score	1. Rare	4. Major	4	

Key questions:	Summary of findings		Updated
Have there been any changes to risk?	**Description**	No change to risk description	
	Owner	No	
	Is risk to be closed	No	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	1 action was closed in Q2	11/08/2023
	New Actions Added	No new actions were added in Q2	

Action Number	Action Description	Last Action Update	Target Date
7228	Ability to balance recruitment to	As per action 8550, demand and capacity analysis in these 7 teams will lead to	31/10/2023

	new roles whilst not destabilising core services	workforce planning exercises, that will include a more systemic approach to workforce.	
7229	Maturity of PCN and secondary care relationships.	Significant improvements seen in place-based discussions. System wide event being facilitated on behalf of the ICB in September to explore the new concept of keyworkers across organisational boundaries.	31/10/2023
8549	Delivery of new access standards for community care.	Access Oversight Group have been working towards the implementation of the new working time standards. Appointment activity pick lists were updated in RiO at the beginning of July. Pick lists have been updated in line with feedback from clinical staff. Community teams have been working through a waiting times comparison report to assess the impact on service users when changing to the new methodology. A data cleanse is being carried out over Q2 2023/24 to ensure that waiting times data is as accurate as possible for assurance reporting. A new waiting times dashboard has been launched for operational staff to help them manage waiting times and understand the waiting times pathway more accurately. Training sessions will be taking place through July/August. The DNA policy refresh has been completed and has been submitted to the policy team for consultation.	31/10/2023
8550	System re-organisation and development of place based teams whilst achieving core offer across all of CNTW community services.	Task and finish groups established to define CNTW's community offer to the system, and to examine best practice in triage and trusted assessment, to inform place-based discussions on new models. 7 'pioneer' community adult teams are testing out new ways of working in collaboration with system partners, starting with demand and capacity/skills analysis.	31/10/2023
8551	Staff fragility and shortages within community teams affecting ability to invest in new roles and meet demand for existing care co-ordination.	Move away from CPA is being trialled in 7 teams as noted in 8550. This is in parallel to the Task and Finish work also noted, and to RiO streamlining exercises to reduce record-keeping burden.	31/10/2023

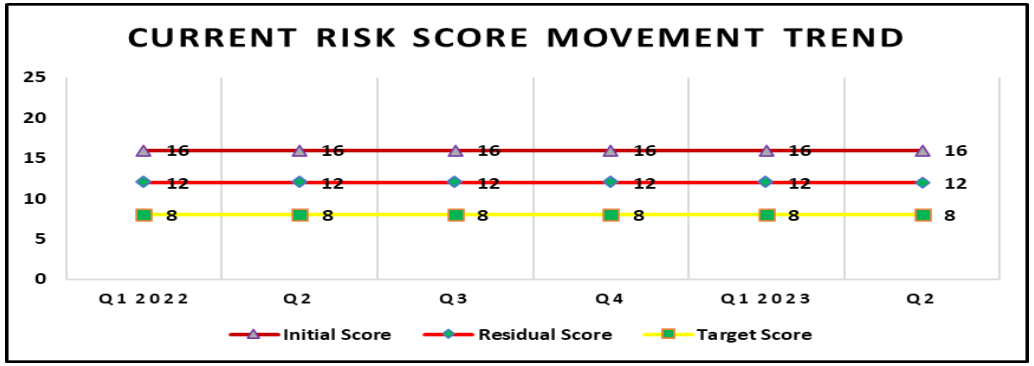
What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	**Where can we gain assurance that the controls, we are placing reliance on are working**
CMHT deliverables for 22/23 realigned and updated to focus on core community model, delivering CPA changes and primary care interface & relationships.	CMHT deliverables for 22/23

BDG realigned to provide monthly oversight of CMHT delivery.	Commissioning and QA report to BDG and TLT. ARRS and Primary care governance framework to support current and new roles.
Waiting times for community access reviewed monthly with focus on long waiters and challenged pathways in place.	Commissioning and QA report to Q&P.
PCN recruitment and additional roles in progress.	Report on access and waiting times challenges to BDG.
Internal Audit - CNTW 22-23 01 Risk Management & BAF	Final report - Good Assurance given

Do all actions have a timescale?	Were risks reviewed in a timely manner?	Expected date risk to be mitigated and brought within the risk category appetite.
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable.

Internal Audit 2022/2023					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
CBU Priority – Should Do - North Locality Community					
Recording of supervision in clinical records - Registered					BAF 1836 SA.2

Date Opened	Risk Description	Risk Appetite – 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)
09/10/2018		
Risks Ref:		
1680 SA5 **RBAC**	If the Trust were to acquire additional services and geographical areas this could have a detrimental impact on CNTW as an organisation. **SA5** Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	
Risk Owner		
Kevin Scollay		

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	4. Likely	4. Major	**16**	Compliance/Regulatory 6-10
Residual Score	3. Possible	4. Major	**12 (Exceeding Appetite)**	Commissioners
Target Score	2. Unlikely	4. Major	8	

Key questions:	Summary of findings		Updated
Have there been any changes to risk?	**Description**	No change to risk description	
	Owner	No	
	Is risk to be closed	No	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	No actions were closed in Q2	
	New Actions Added	No new actions were added in Q2	

Action Number	Action Description	Last Action Update	Target Date
6262	Agree Estates Strategy for North Cumbria	Agreed CNTW will not run the Estates Team for NCIC, CNTW will run its own Estates services supporting services in North Cumbria. Verbal confirmation that legal documents for Carlton Clinic have been signed by NCIC awaiting copies. New target date 31.10.23	31/10/2023
8435	Achievement of North Cumbria CQC must do improvement areas Q4.	2 further Must Do Action Plans closed at Board of Directors on 6th September 2023. 9 Action Plans remain open. Focused discussion at CQC Inspection Steering Group on remaining Must Do Themes (training, clinical supervision, rapid tranquilisation / physical health monitoring and staff and patient incident debriefs) to take place on 18th September 2023.	29/12/2023
11634	CQC Inspection Steering Group set up in April to review all outstanding areas of improvement (Must Dos and Should Dos)	17 Must Do Action Plans remain open. 4 will close once transfer of services to Sycamore Unit has taken place in mid-October. Focused discussion at CQC Inspection Steering Group on remaining Must Do Themes (training, clinical supervision, rapid tranquilisation / physical health monitoring and staff and patient incident debriefs) to take place on 18th September 2023.	29/12/2023
11635	Trust Leadership Team to receive monthly updates on outstanding areas of improvement	Focused discussion at CQC Inspection Steering Group on remaining Must Do Themes (training, clinical supervision, rapid tranquilisation / physical health monitoring and staff and patient incident debriefs) to take place on 18th September 2023.	29/12/2023
11636	Board of Directors to receive more regular updates on the position around Must Dos on a Quarterly basis Q1 (23/24) due 04.07.23	Focused discussion at CQC Inspection Steering Group on remaining Must Do Themes (training, clinical supervision, rapid tranquilisation / physical health monitoring and staff and patient incident debriefs) to take place on 18th September 2023.	29/12/2023

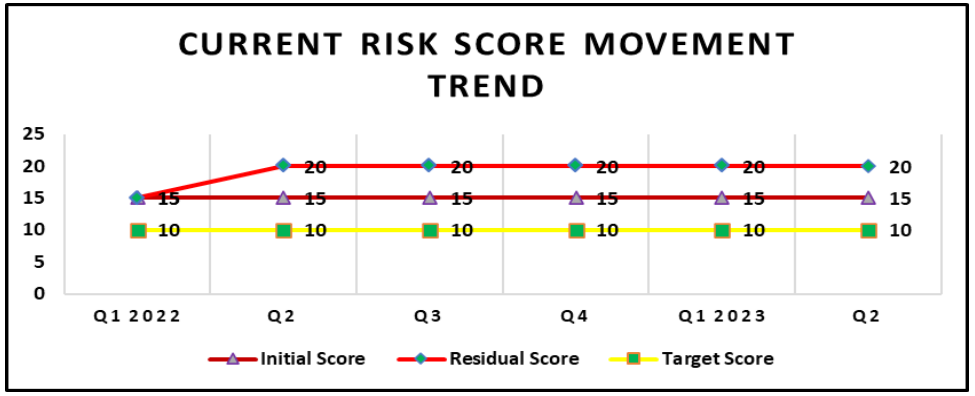
What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	Where can we gain assurance that the controls, we are placing reliance on are working
North Cumbria 2 years on Presentation, presented to Council of Governors 25.11.21	Copy of presentation
Pressures on Systems across the whole organisation presentation to the Board 23.11.21	Copy of presentation.

Contract agreed and completed		Contract report- Reviewed RBAC
Maintain oversight during the establishment of Lotus Ward		Closed Trust Board
Internal Audit - CNTW 22-23 01 Risk Management & BAF		Final report - Good Assurance given
Do all actions have a timescale?	**Were risks reviewed in a timely manner?**	**Expected date risk to be mitigated and brought within the risk category appetite.**
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable.

Internal Audit 2022/2023					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q2					

Date Opened	**Risk Description**	**Risk Appetite – 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)
15/03/2018		
Risks Ref:		

1687 SA4 **RBAC** **Risk Owner** Kevin Scollay	That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our key programmes. **SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled	

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	3. Possible	5. Catastrophic	15	Financial/VfM 12-16
Residual Score	4. Likely	5. Catastrophic	**20 (Exceeding Appetite)**	Efficiency
Target Score	2. Unlikely	5. Catastrophic	10	

Key questions:	**Summary of findings**		**Updated**
Have there been any changes to	**Description**	No change to risk description	
	Owner	No	
	Is risk to be closed	No	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	2 actions were closed in Q2	15/08/2023
	New Actions Added	1 new action was added in Q2	15/08/2023

Action Number	**Action Description**	**Last Action Update**	**Target Date**
9660	To develop plans to reduce agency spend to 1 million a month by 31.03.23. Including Board report 29.11.22.	No further update. Review in six months.	08/12/2023
12208	To review locally owned agency meeting within groups and monthly BDG meeting.		20/12/2023

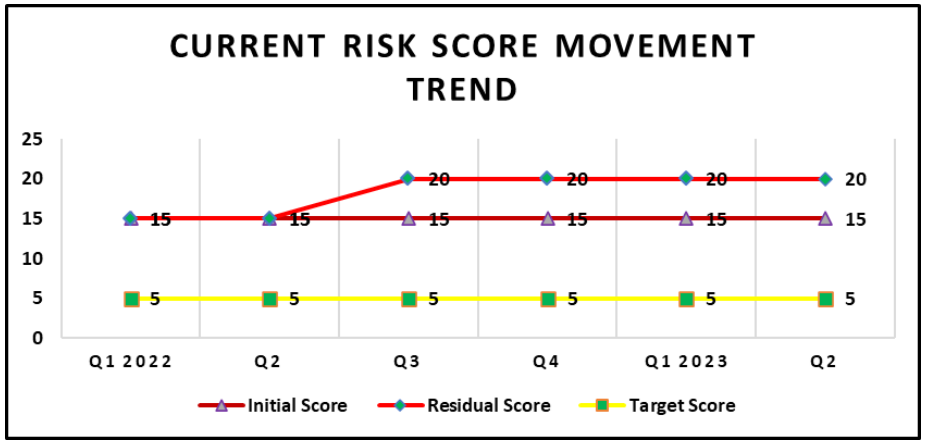
What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	**Where can we gain assurance that the controls, we are placing reliance on are working**

Recovery Plan went to October Board including a half year review.		Copy of Recovery Plan
Internal Audit of CNTW Key Finance Systems (202122 03).		Final report dated 20.07.22 good level of assurance.
Programme agreed for capacity to care and Trust Innovations capacity expanded		Capacity to care programme, report to BDG and Executive Management Group (EMG)
Financial and Operating procedures		Policy/PGN
Internal Audit - CNTW 22-23 01 Risk Management & BAF		Final report - Good Assurance given
Do all actions have a timescale?	**Were risks reviewed in a timely manner?**	**Expected date risk to be mitigated and brought within the risk category appetite.**
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable.

Internal Audit 2022/2023					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q2					

Date Opened	**Risk Description**	**Risk Appetite – 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
07/11/2019		

Risks Ref:		possibility of financial loss and comply with statutory requirements. (12-16)
1762 SA4 **RBAC** **Risk Owner** Kevin Scollay	Restrictions in Capital expenditure due to national limits and the Trusts own cash availability may lead to increasing risk of harm to patients when continuing to use sub optimal environments **SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled	

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	3. Possible	5. Catastrophic	15	Financial/VfM 12-16
Residual Score	4. Likely	5. Catastrophic	**20 (Exceeding Appetite)**	Sustainability
Target Score	1. Rare	5. Catastrophic	5	

Key questions:	Summary of findings		Updated
Have there been any changes to risk?	**Description**	No change to risk description	
	Owner	No	
	Is risk to be closed	No	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	No actions were closed in Q2	
	New Actions Added	No new actions were added in Q2	

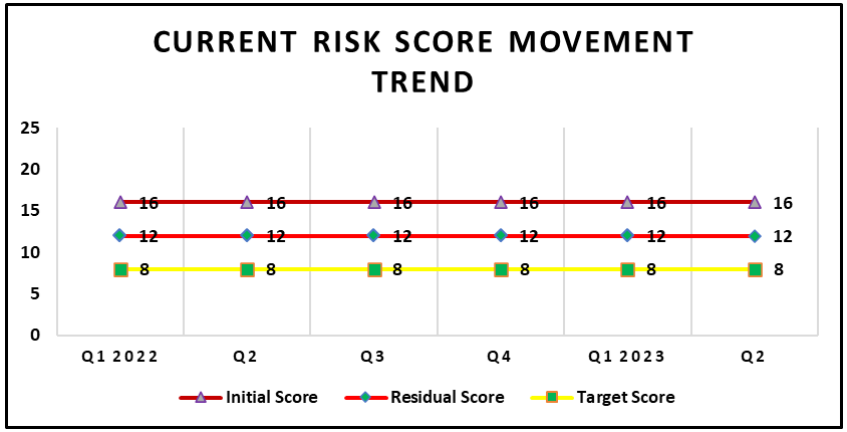
Action Number	Action Description	Last Action Update	Target Date
5552	Capital Strategy for North Cumbria and Rose Lodge to be developed, to be incorporated into ICS strategy prioritisation for national capital funding	Capital plan approval at Board on 05.04.23. Review in 6 months' time to ensure strategy for North Cumbria and Rose Lodge are included in long term capital plan.	31/10/2023

What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	Where can we gain assurance that the controls, we are placing reliance on are working
ICS support nationally and funding identified	ICS bid document
Asset sales now identified	Standard reporting at Executive Management Group (EMG) and RBAC
Going Concerns Reporting	Discussed and in minutes of Audit Committee
Operational mitigations: Additional staffing at Rose Lodge. Interim funding for North Cumbria. Integrated Care Facility in Newcastle	Minutes of Executive Management Group (EMG) meeting
Internal Audit - CNTW 22-23 01 Risk Management & BAF	Final report - Good Assurance given

Do all actions have a timescale?	Were risks reviewed in a timely manner?	Expected date risk to be mitigated and brought within the risk category appetite.
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable.

Internal Audit 2022/2023						
Resource and Business Assurance Committee	**2023/2024**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**	

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q2					

Date Opened	Risk Description	Risk Appetite – Climate & 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)
24/09/2020		
Risks Ref:		
1853 SA4 **RBAC**	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** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled	
Risk Owner		
Kevin Scollay		

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	4. Likely	4. Major	**16**	Climate & Ecological Sustainability (6-10)
Residual Score	3. Possible	4. Major	**12 (Exceeding Appetite)**	Green Plan
Target Score	2. Unlikely	4. Major	8	

Key questions:	Summary of findings		Updated
Have there been any changes to risk?	**Description**	No change to risk description	
	Owner	**Yes, risk transferred from James Duncan to Kevin Scollay**	19/09/2023
	Is risk to be closed	No	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	Yes 2 actions were closed in Q2	19/09/2023
	New Actions Added	Yes 2 new actions were added in Q2	19/09/2023

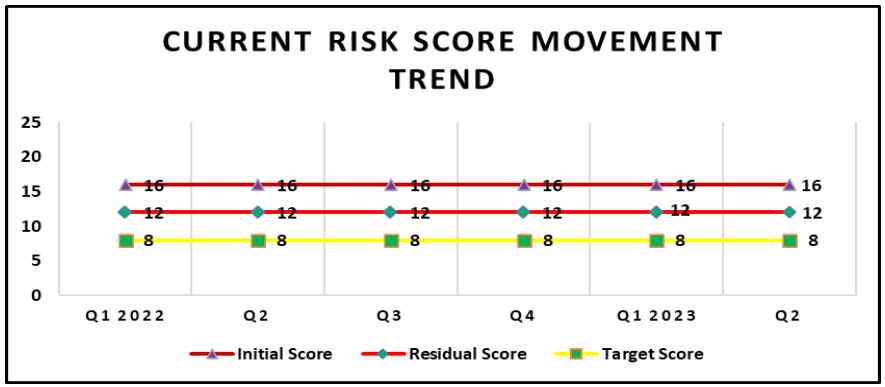
Action Number	Action Description	Last Action Update	Target Date
6614	Routine reporting of carbon intensive activity, sustainable transport measures and single use plastic is underdeveloped.	The Trust Green Plan won't be refreshed until after the strategy is launched. This action is on hold until this happens.	29/12/2023
12533	Green Plan refresh		29/12/2023
12534	Agree governance arrangements for monitoring and delivery of the Green		29/12/2023

What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	Where can we gain assurance that the controls, we are placing reliance on are working
Commitment of CNTW - Declared Climate Emergency	CNTW Climate Health Programme
Plan to reduce carbon omission to net zero by 2040. Opportunities for decarbonisation funding actively sought.	Minutes of Executive Management Group (EMG has replaced TLT)
Executive Management Group meeting - monthly	Minutes of Executive Management Group (EMG has replaced TLT)
The Board approved Green Plan has annual objectives which are monitored via TLT and RBAC.	Minutes of Executive Management Group (EMG has replaced TLT)
Internal Audit - CNTW 22-23 01 Risk Management & BAF	Final report - Good Assurance given

Do all actions have a timescale?	Were risks reviewed in a timely manner?	Expected date risk to be mitigated and brought within the risk category appetite.
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable.

Internal Audit 2022/2023					
Resource and Business Assurance Committee	2023/2024				
	Q1	Q2	Q3	Q4	BAF/SA
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q2					

Risks Ref: 06/11/2018	**Risk Description**	**Risk Appetite – Quality Effectiveness -** CNTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users. (6-10)
1694 SA3 **People Committee** **Risk Owner** Ramona Duguid	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. **SA3** A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	

	Likelihood	**Impact**	**Score**	**Risk Category/subcategory**
Initial Score	4. Likely	4. Major	**16**	Quality Effectiveness (6-10)
Residual Score	3. Possible	4. Major	**12 (Exceeding Appetite)**	Services
Target Score	2. Unlikely	4. Major	8	

Key questions:	**Summary of findings**		**Updated**
Have there been any changes to risk?	**Description**	No change to risk description	
	Owner	No	
	Is risk to be closed	No	

Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	No actions were closed in Q2	
	New Actions Added	No new actions were added in Q2	
Action Number	**Action Description**	**Last Action Update**	**Target Date**
2243	Difficulties recruiting registered and unregistered nursing staff.	Although the vacancy position for registered nurses has improved, strategic work is in progress to identify and address the impact of the proportion of registered nurses who are undertaking preceptorship. Work is also in progress to clarify the criteria for appointment to band 6 posts, including community posts. A pilot is in progress involving internationally educated adult nurses working into community teams, recognising the importance of parity of esteem of mental and physical health. Collaboration with NHSE continues to recruit to unregistered nursing staff, employing a targeted approach by Locality and service and a focus on retention.	29/12/2023
2860	Executive Awareness of International recruitment through Medical Director, Trust aware for medical recruitment as a whole through medical managers.	Recent campaign for international fellows underway. Interviews in April / May 2023. Prospective 24 fellows starting with the Trust from October 2023, subject to visa waiting times and control.	29/12/2023
6092	Risk to be discussed at the Medics Meeting and actions to be updated re: medical staffing.	Focus on encouraging retire and return to support workforce. Remote working consultant JD for Cumbria. Introduction of the Specialist grade posts. Localities to identify posts.	29/12/2023
10236	CA-22.063.01 - Safeguarding Adults at Risk	CEC confirmed this action has been paused.	29/12/2023

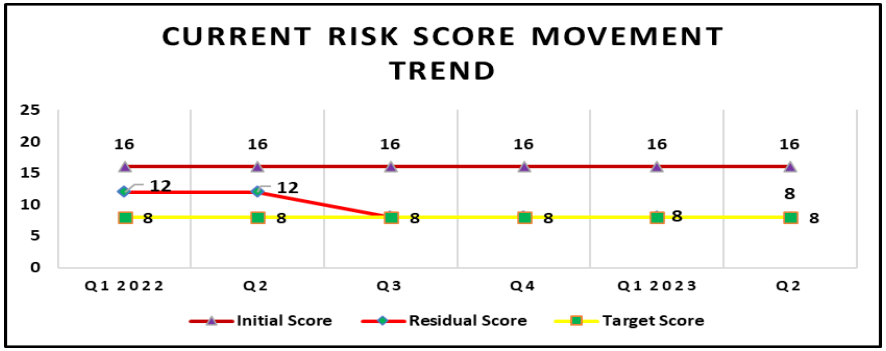
What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	**Where can we gain assurance that the controls, we are placing reliance on are working**
Medical Induction Programme	Delivery of medical induction programme
OPEL Framework	OPEL Framework Documents
The medical recruitment functions have been moved to the medical staffing team	The medical staffing team manage the medical recruitment function
Medical Induction Programme	Delivery of medical induction programme

Internal Audit - CNTW 22-23 01 Risk Management & BAF		Final report - Good Assurance given
Do all actions have a timescale?	**Were risks reviewed in a timely manner?**	**Expected date risk to be mitigated and brought within the risk category appetite.**
Yes, all timescales are added to the actions	Yes	There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable.

Internal Audit 2022/2023					
People Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
People Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Should Do – Trust Priority Clinical Audits – Re audit					
CA-22.063.01 - Safeguarding Adults at Risk – Re audit Q3					BAF 1694 SA.3

Date Opened	**Risk Description**	**Risk Appetite – Quality Effectiveness -** CNTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users. (6-10)
21/09/2021		
Risks Ref:		

2041 SA5 **Provider Collaborative** **Risk Owner** Kevin Scollay	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. **SA5** Working with and for our communities - We will create trusted, long-term partnerships that work together to help people and communities.	

	Likelihood	Impact	Score	Risk Category/subcategory
Initial Score	4. Likely	4. Major	**16**	Quality Effectiveness (6-10)
Residual Score	2. Unlikely	4. Major	**8 (Within Appetite)**	Services
Target Score	2. Unlikely	4. Major	8	

Key questions:	Summary of findings		Updated
Have there been any changes to risk?	**Description**	No change to risk description	
	Owner	No	
	Is risk to be closed	**Yes – request to close risk will go to next Board meeting on 01/11/2023**	
Have actions progressed?	**Control and Assurances added.**	No	
	Actions Completed & Closed	No actions were closed in Q2	
	New Actions Added	No new actions were added in Q2	

Action Number	Action Description	Last Action Update	Target Date
6593	Look to increase LP models across Trust footprint.	Action ongoing. Looking to complete and close in October	31/10/2023
8250	CA-21-0001: Allied Health Professional (AHP) Continuing Professional Development (CPD) Audit 2021	Repeat the AHP CPD audit - allowing time for toolkit to be embedded, audit leads to be identified, audit champions group to be reconvened. Propose re-audit in Q3 with support from audit department, analysis and report in Q4. Explore possibility of a PGN re CPD or increasing emphasis in appraisal policy. Ensure CPD is reviewed at appraisal -to be reinforced through comms directly with AHPs and possibly via the Bulletin and assessed through the re-audit.	31/10/2023

What are the strongest controls/systems are already in place to help secure delivery of the objective and manage the risk (up to 5)	Where can we gain assurance that the controls, we are placing reliance on are working

Partnership in place across ICS for MHLDA Specialised Services.		PB Papers and PC Committee oversight
Membership of other ICS workstreams (LD, Acute pathways).		Regular updates to Executive Management Group (EMG which had replaced TLT) and Board.
Leadership of ICS MH Workstream.		Regular updates to Executive Management Group (EMG which had replaced TLT) and Board.
Medical Director member of Integrated Care Board (ICB)		Regular updates to Executive Management Group (EMG which had replaced TLT) and Board.
Internal Audit - CNTW 22-23 01 Risk Management & BAF		Final report - Good Assurance given
Do all actions have a timescale?	**Were risks reviewed in a timely manner?**	**Expected date risk to be mitigated and brought within the risk category appetite.**
Yes, all timescales are added to the actions	Yes	Risk already within risk category appetite. Request to close risk will go to next Board meeting on 01/11/2023

Internal Audit 2022/2023					
Provider Collaborative	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
Internal Audit - CNTW 22-23 01 Risk Management & BAF – Good level of assurance	*				**All BAF risks**

Clinical Audit Plan					
Provider Collaborative	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
CA-23-001 CPD audit for AHP's (Trustwide) Should Do Trust Priority				*	BAF 2041 SA5

3.0 New BAF risks (from Q3 2023/24)

BAF RISK NUMBER 1	Due to increased demand and capacity the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services. SA1

Strategic ambition	Quality care, every day	**Residual rating (L X I)**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Quality (safety) – 6-10	16 (4 x 4)	16 (4 x 4) ⟷	16 (4 x 4) ⟷			8 (2 x 4)
Review date	20 September 2023						
Executive Lead	Ramona Duguid						
Lead Committee	Quality and Performance						

Context of the risk (narrative and background)	**Gaps in control and/or gaps in assurance**
The vast majority of services provided by CNTW are community based including provision to children, adults and older people within our seven place-based areas. Whilst the demand for services has remained generally consistent in most areas, there has been a marked increase in demand within some pathways, most significantly CYPS neuro. Most individuals receiving care from CNTW are open to community services only, be that crisis teams or CTT's. For a small number of service users their clinical presentation is such that they require inpatient care to augment their treatment. The ability to access beds in a timely fashion has a significant impact from an individual, family, Trust, and system perspective. Any shortfalls or deficiencies in community provision may adversely impact on the number of people requiring a period of inpatient care.	• Full implementation of SBAR (Situation, Background, Assessment, Recommendation). • Keeping In Touch process for service users on assessment waiting lists. • Introduction of Dialogue+. • Fully implement 4 week waits. • Introduce the Trusted Assessment concept into community services. • Confirm the role and function of both community and crisis services at the interface of these pathways. • Limited acute inpatient alternatives at a place or system level (crisis housing) • Lack of specialist provision for some client groups (autism). • Limited availability of seven-day week service provision from both an inpatient and community perspective. • Lack of intermediate care opportunities.

Progress		
What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**

• Development of a Community Oversight Group with associated task and finish groups to support clinical change to enhance input and reduce breaches. • Established key task and finish groups to address the following areas: - role and function of CTTs - role and function of SPA/IRS - CYPS neuro - Trusted Assessment • Active participation in the development of community transformation models within the seven place-based areas. • Identification of seven pioneer teams (1 per place-based area) to pilot community initiatives e.g., SBAR. • Working with primary care on the development of ARRS mental health workers to reduce demand on secondary care services. • Development of a clinical delivery model to support more efficient and effective care delivery. • Established an Enhanced Bed Management service to promote timely discharge and re-drafted admission and discharge policy. • Reviewing the role and function of the discharge facilitator roles throughout the Trust. • Reviewing working practices adopted on inpatient units to support improved flow. • Working with Third Party Providers to provide additional support for hospital discharge. • Participated in the NHS England 100 Day Challenge to obtain key learnings and processes to help support more efficient and effective inpatient stays.	• Community Oversight meetings reviewing community compliance against key targets that impact upon CTTs, Crisis teams and Liaison services. • Review of monthly ARRs summaries that highlight performance and stakeholder experience. • Reduction in complaints and SI's • Improved performance reporting via the Integrated Performance Report (IPR). • Feedback from Keeping In Touch processes. • Improved alignment between community and inpatient pathways as monitored by the Programme Boards. • Review of, and reduction in the number of patients in receipt of out of area treatments. • DTOC meetings / reports. • Review of discharge information enabling a compare, and contrast between each of the adult mental health wards.	1. Full implementation of community transformation models within seven place-based areas - **Throughout 24/25** 2. Continue to work with commissioner colleagues to obtain years 3 ARRS funding – **Throughout 24/25** 3. Review the resource implication of adopting the Keeping in Touch process to the Trusts assessment waiting list over and above the treatment waiting list – **Q3/Q4, 23/24** 4. Implement optimum MDTs within Community teams – **Q4, 23/24** 5. Undertake an analysis of the resource implications and ability of the Trust to provide a broader range of seven day a week services – **Q1 24/25.** 6. Ensure inpatient care provision considers key features of recent NHSE publications including: • Acute inpatient mental health care for adults and older people • Commissioning Framework for Mental Inpatient Services **During 23/24 and onwards.** 7. Undertake further work on key aspects of the 100-day challenge e.g., expansion of Red to Green, MADE and super MADE events – **Q1 24/25** 8. Work with NTW Solutions on the development of an Integrated Inpatients Estates Plan – **Q4 23/24.** 9. Pursue business case opportunities to optimise bed numbers in key geographical service areas – **Q3 23/24.** 10. Work with the ICB and NHSE on the

• Appointed 2 Senior Case Managers to provide support and oversight of key tasks linked to effective bed management, MADE events etc. • Development of an emerging Quality Framework for Inpatient services. • Reviewing the role and function of the Trusts crisis teams to better align with the organisations transformational journey. • Dashboard review highlighting clients seeking admission which includes current clinical status, location etc. • Daily Locality flow meetings.		utilisation of any available resources to develop inpatient alternatives and or intermediate care options **Q4 23/24.** 11. Work with the ICB and other stakeholders on the development of a sustainable inpatient bed model for the system, promoting the concept of Centres of Excellence – **Throughout 24/25**
Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 2	Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern. SA1

Strategic ambition	Quality care, every day	Residual rating	Q1 rating and movement	Q2 rating and movement	Q3 rating and movement	Q4 rating and movement	Target score
Appetite category	Quality (safety) – 6-10	16 (4 x 4)	16 (4 x 4) ⟷	16 (4 x 4) ⟷			8 (2 x 4)
Review date	20 September 2023						
Executive Lead	Rajesh Nadkarni						
Lead Committee	Quality and Performance						

Context of the risk (narrative and background)	Gaps in control and/or assurance
The Trust has robust incident reporting and review processes in line with the Serious Incident Framework (2015) which provide assurance to the board and external partners / regulators. The new Patient Safety incident response framework (PSIRF) requires Trusts to change their focus of incident reviews to increase learning and improvement. This requires a change in the incident processes and reviews. There are risks if these changes are not successfully implemented.	• Implementation of PSIRF will require extensive engagement and training of staff to ensure that their practice changes to align with the new systems, processes and culture changes. • Outcome measures will need to move from numbers and data around compliance with timescales to assessing how learning is shared and improvements embedded.

Progress

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)	What further actions do we need to take to address the gaps in control (including target dates for completion)
• PSIRF Core Project Team in place led by Rajesh Nadkarni (with Internal Audit input) • Clear governance and assurance in place on PSIRF implementation. • Training needs analysis in place • Communication plan in place (including staff, Board, Governors, service users and carers and workforce).	• Monitoring and review of the PSRIF project plan. • Reduction in the number of SIs. • Reduction in the number of Independent Investigations. • Reduction in the number of complaints	1. Outcome measures to be developed - **Nov 23** 2. Training of staff in new investigation methods and engagement - **to start in Nov 23 with planned trajectories**

Updates since last review

New control	New assurance	New actions
N/A	N/A	N/A

BAF RISK NUMBER 3	Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. SA1						
Strategic ambition	Quality care, every day	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Quality (effectiveness and experience) 6-10	20 (4 x 5)	15 (3 x 5) ↓	15 (3 x 5) ⟷			10 (2 x 5)
Review date	20 September 2023						
Executive Lead	Sarah Rushbrooke						
Lead Committee	Quality and Performance						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
The Trust has not had a CQC Comprehensive inspection since 2018. It is likely this will happen in 2023/24 so we are required to demonstrate compliance against the CQC registration, regularity requirements and Key Lines of Enquiry. There has been slow progress in closing some of the existing Must Do actions, particularly following the transfer of Cumbria services in 2019. Change of CQC leadership team and Executive with CQC responsibility.	• Newly emerging relationship with new CQC team and new Executive team and confidence in the emerging relationship with new CQC team • Closure of action plans relating to new buildings and environment may slip as works are being delayed.

Progress

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Monthly CQC Compliance meeting and fortnightly Steering Groups in place • Monthly reporting of Must Do actions through Q&P and Board – reducing number and action plans. • Monthly agenda at BDG - Q&P • MHA Reviewer Visits in place – sharing of reports and aligning actions to CQC Must Dos/themes. • Programme of mock CQC Inspections led by Senior Clinician and CQC	• Reduction in CQC Action plans from 51 – 21 • Updates on areas of improvement and good practice at CQC Compliance group and BDG - Q&P. • Improved outcomes following MHA reviewer visits and actioning of recommendations.	1. Continue with regular informal connection and formal meetings with CQC leadership team – **ongoing throughout 2023/24** 2. Sharing of good practice and areas of improvement – ongoing throughout 2023/24 3. Monthly updates to Board on progress against closure of action plans – **ongoing throughout 2023/24** 4. Updates on building works to CQC – **ongoing throughout 2023/24**

compliance lead • Peer Review visits • CQC Relationship Meetings bi-monthly. • Learning and bench marking through oversight of other organisational CQC Inspection Reports – most recent Benchmark against Manchester MH • CQC Update sessions planned at Ward managers Community of Practice – August 2023 • CQC inspection preparedness programme in place. Task and Finish Groups include Governor representation.		5. Delivery of CQC 'every day is a quality day' preparedness programme – **Q3 and Q4 2023/24**
Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 4	Failure to deliver our transformation plans around the model of care to address issues relating to community and crisis infrastructures, and demand for inpatient provision which could compromise quality, safety, and experience of service users.

	SA2						
Strategic ambition	Person-led care, when and where it is needed	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Model of Care 12-15	12 (3 x 4)	12 (3 x 4) ⟷	12 (3 x 4) ⟷			8 (2 x 4)
Review date	20 September 2023						
Executive Lead	Ramona Duguid						
Lead Committee	Quality and Performance						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
The Trust as a discreet organisation and a key partner within the NENC ICS system is going through a significant period of change. This has been brought about due to a number of factors linked to: - changing public expectations - available resources - our working relationships with key partners - national policy context. All of the above are key catalysts for change. We know that our transition arrangements between clinical pathways are not robust, leading to gaps in provision of care. Due to the current limitations of the community and crisis infrastructure, demand for inpatient provision continues impacting on our ability to deliver high quality therapeutic care, an increase in out of areas placements and an increase of patients who are CRFD.	• Introduction of a more appropriate efficient and effective operating model to support transformational change and sustainable care delivery. • Validation and/or support to date for the developing clinical model. • Further work required to align our Trust Strategy (With you in Mind) to an emerging estates strategy. • Lack of clarity on the emerging or agreed community transformation models within our seven place-based areas.

Progress

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• The Trust has established discreet Programmes of work to oversee transformational change within our clinical services. Each of these Programmes are supported by discreet projects of work.	• Monitoring progress against project plans in place with leads and delivery dates. • Greater and wide understanding of the key programmes and project outputs by Trust staff.	1. Specific action required on clinical service outliers including: CYPS neuro and Gender services – **Q3/Q4 2023/24** 2. Review the workplan outputs of the seven pioneer teams – **end of Q4 2023/24**

• We are engaging with key internal stakeholders via the Trust Leadership Forum, Ward Managers Meetings, Community of Practice, Service User and Carer Forums etc. • Development of a Primary Care Partnership Plan • Executive Representation at key ICB governance and leadership meetings • Developing an engagement and involvement plan with internal and external stakeholders.	• 7 Pioneer Teams developed. • Evidence of improved engagement via specific workshop attendance, levels of feedback etc. • Greater influence over the system wide Mental Health, Learning Disability and Autism agenda evidenced by inclusion of MHLDA in objectives and plans at ICS/ICB level. • External validation by commissioners and other key stakeholders.	3. Agree a costed MDT model for acute inpatient services – **Q4 2023/24** 4. Successfully transition away from CPA – **during 2024/25** 5. Successfully implement 111 service delivery model to support the inpatient pathway – **Q1 24/25** 6. Respond effectively to any impact of the developing RCRP initiative – **Q4 23/24**

Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 5	Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3

Strategic ambition	A great place to work	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Workforce/staffing 6-10	16 (4 x 4)	16 (4 x 4) ⟷	16 (4 x 4) ⟷			8 (2 x 4)
Review date	20 September 2023						
Executive Lead	Lynne Shaw						
Lead Committee	People Committee						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
To provide safe services and appropriate therapeutic interventions it is important to ensure that the workforce model across the Trust is fit for purpose with staff in the right numbers and with the right skills. It is imperative that a sustainable workforce plan is in place to reduce the risks to providing safe, high-quality care. This includes ensuring staff have the required skills, competencies, and training to undertake their roles. A sustainable workforce plan also needs to include plans to achieve our Strategic objectives aligned to the commitments to our workforce in relation to personal and professional development.	• Absence of a sustainable workforce plan. • Establishment control to be reviewed to ensure accurate recording and reporting of vacancies. • Current workforce skills are not currently recorded and mapped against post requirements. • Skills gaps are not identified, and adequate training put in place to address the shortfalls. • Inclusive recruitment work has had an impact on increasing the BAME workforce but predominantly this is in lower banded posts. • Strengthening of internal process for accessing development monies required. • Release of staff to undertake relevant training and development opportunities is currently a challenge. • Lack of joined up approach between appraisals and training requirements. • Challenges ensuring the temporary workforce maintain the required skills. • More robust recording and reporting mechanisms is required to enable leadership and management development and succession planning.

Progress		
What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• A training needs analysis outlining training requirements is in place for all professions/service areas. • CPD and Workforce Development Monies is ring-fenced for the development of medical/non-medical staff. • Leadership and management skills are in place across the Trust to support succession planning. • International recruitment programme for medical, nursing and allied health professionals. • Apprenticeship model in place with 2-, 3-, 4- and 5-year schemes. • Sufficient training places available across all mandatory clinical skills courses. • Training Needs Analysis is in place for all professions/service areas. • Statutory and Mandatory training requirements (10 core subjects) are in place as part of induction. • Leadership and Management Development Programmes	• Reduction in vacancies, locum, and agency costs. • Improvement in training compliance. • Reduction in employee relations issues (incl., grievances and disciplinaries). • Reduction in incidents. • Increase in the number of nurses coming through the Trust because of the CNTW Academy 'grow your own' approach. • Inclusive recruitment work has had an impact on increasing the BAME workforce. • International recruitment and the GMC Fellowship scheme has increased the supply of doctors working across the Trust. • Adequate training places are available.	1. Complete work on the clinical model. 2. Develop a sustainable workforce plan including mapping of skills against role requirements. 3. Introduce a robust establishment control process. 4. Development of support worker programme 5. Training Needs Analysis to be reviewed 6. Recording of skills on ESR 7. Development of a sustainable workforce plan.

Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 6	Risk of increased staffing costs from use of temporary staff impacting on quality of care and financial sustainability. SA3						
Strategic ambition	A great place to work	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Financial 6-10	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)			8 (2 x 4)
Review date							
Executive Lead	Kevin Scollay						
Lead Committee	Resource and Business Assurance Committee						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
For several years, it has been a challenge to recruit into some posts. This has resulted in a high use of locum/agency in these areas. As well as the financial impact, this impacts on the quality and safety of service and lack of continuity of care for a service user population where this is important. Temporary staffing costs, particularly agency usage, increased sharply during the 2021/22 financial year. Temporary staff are less familiar with Trust procedures and culture, which increases the chances of incidents which impact on the quality of care for our service users. The increase in usage of temporary staffing resource is also financially unsustainable. Rules around agency usage are also regularly breached from a regulatory perspective such as capped agency expenditure levels, off framework usage and price cap breaches. These breaches bring with them a risk of regulatory intervention by NHSE.	• Absence of a long-term sustainable workforce plan. • Absence of a long-term sustainable financial plan. • Review of the Trust's clinical model / care and treatment model. • Clarity on links between financial planning and delivery of the key programmes of work.

Progress

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Group based agency control meetings. • Agency control procedures.	• Reporting of agency expenditure via BDG	1. Reduce agency expenditure to below cap levels.

• Implementation of NHSE controls e.g. non clinical and off framework actions.	• Quarterly well led framework meetings include reporting around agency usage • Reporting of agency expenditure via EMG. • Monthly Board scrutiny and review at Board development sessions. • Quarterly review of agency expenditure via finance reporting at RABAC	2. Eliminate off framework agency usage. 3. Eliminate nonclinical agency usage.
Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 7	Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up. SA3						
Strategic ambition	A great place to work	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Workforce/staffing 6-10	12 (3 x 4)	12 (3 x 4) ⟷	12 (3 x 4) ⟷			8 (2 x 4)
Review date	20 September 2023						
Executive Lead	Lynne Shaw						
Lead Committee	People Committee						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
The Trust aims to be a great place to work. Poor culture will have a significant impact on the attraction, recruitment, and retention of staff. It is important that there is adequate support in place for health and wellbeing and inclusion. Flexible working and work/life balance is important to staff as is a sense of belonging. This is measured in the staff survey and quarterly staff People Pulse survey, so it is able to be monitored regularly. Creating a compassionate just and learning culture will have an impact on staff wellbeing, patient safety, a sense of psychological safety which will in turn reduce sickness absence, turnover, investigations. It is important that staff have the confidence to raise concerns to ensure that patient and staff safety is maintained. Some staff are reluctant to raise concerns as they fear retribution and/or feel that nothing is done with the issues raised.	• Flexible working is not monitored or easily reportable • Full implementation of PSIRF • Further work on the development and implementation of compassionate, just and learning culture • Support for staff networks in terms of governance arrangements and guidance to address concerns raised. • Clarity on future Occupational Health provision.

Progress

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Regular monitoring of People Metrics e.g.,	• Improvements in People Metrics • Reduction in Employee Relations cases	1. More information to be stored in ESR.

- Turnover - sickness absence - reasons for absence - morale and motivation - investigations - Freedom to Speak up concerns • Occupational Health service and monthly contract review • Staff Psychological Service • Review point meetings for absence • Reasonable Adjustments process in place with central budget • Staff Networks with identified Chairs (Exec sponsors for each network) • Freedom to Speak up Guardians • Thrive Website • Health and Wellbeing approach (STAR) • Supportive workforce policies in place • Freedom to Speak up Guardians have regular contact with Trust Board members (including names NED) • Concerns are shared monthly at EMG, BDG and bi-annually at the People Committee and Trust Board where themes are discussed. • Freedom to Speak up Guardians have high visibility across the Trust	and more learning opportunities identified. • Improved staff survey and People Pulse results relating to speaking up.	2. Managers to be skilled and competent, completion of management skills components, measured through appraisal. 3. Further work on the development and implementation of compassionate just and learning culture 4. More utilisation of the Human Factors approach 5. Improve the culture and environment for the temporary workforce to give greater confidence to raise concerns.

Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 8	Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care SA4						
Strategic ambition	Sustainable for the long term, innovating every day	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Financial 6-10	16 (4 x 4)	16 (4 x 4) ⟺	16 (4 x 4) ⟺			10 (2 x 5)
Review date							
Executive Lead	Kevin Scollay						
Lead Committee	Resource and Business Assurance Committee						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
The Trusts is currently operating with an underlying financial deficit and has included assumptions within its current year financial position to eliminate the deficit which were unidentified at the start of the financial year. The Trust continues to operate within a challenging and uncertain financial environment and a level of forecast risk within year end projections. The Trust is at risk of operating with insufficient financial resources and be subject to regulatory action for failing to meet financial duties if it is unable to reduce expenditure run rates.	• Absence of an in-year recovery plan for Central Locality • Absence of a medium/long-term financial plan.

Progress

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Group based agency control meetings. • Agency control procedures. • Implementation of NHSE controls e.g. non clinical and off framework actions. • Reduction of unidentified CIP within Trust financial plans • Ongoing management of in year financial position through exceptional escalation	• Monthly reporting of financial performance via BDG. • Quarterly well led framework meetings of overall financial position. • Reporting of the overall financial position to BDG. • Monthly Board scrutiny and review at Board development sessions.	1. Development of in year recovery plan for Central locality. 2. Identification of Trust wide drivers of the deficit. Medium term financial plan 3. Return completed and shared with NHSE. To be brought for Board discussion in September.

meetings. • Development of Group specific in year recovery plans and actions. • Identification of underlying financial deficit to support medium term planning	• Quarterly review of overall financial position via finance reporting at RABAC.	4. Currently engaged with ICS wide process – weekly meetings with ICS FDs to support.
Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 9	Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure. SA4						
Strategic ambition	Sustainable for the long term, innovating every day	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Estate infrastructure 12-15	20 (4 x 4)	16 (4 x 4) ↓	16 (4 x 4) ↔			8 (2 x 4)
Review date							
Executive Lead	Kevin Scollay						
Lead Committee	Resource and Business Assurance Committee						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
The regulatory framework within which the NHSE operating is increasingly challenging i.e., reducing levels of capital resource. These reductions in resource may lead to harm to service users if not managed effectively. This includes the risk of failing to properly maintain the estate to sufficient standards to properly care for our service users.	• Lack of support at national level for the CEDAR Programme Business Case addendum causing potential delays to the scheme. • Clarity of the Trust's medium/long-term Estates Strategy.

Progress

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Financial planning budgets • Working capital management	• Delivery of workforce strategy • RPIW Medical Recruitment outcomes	1. Business case addendum for CEDAR to be approved by NHP/Treasury

• Going Concerns Reporting • OBC approved nationally - CEDAR business case including inherent improvement to revenue position • CEDAR Programme Board established with key partners • Business case approved interim solutions for WAA, Newcastle and Gateshead - Building programme in place • Operational mitigations: Additional staffing at Rose Lodge. Interim funding for North Cumbria. • Integrated Care Facility in Newcastle • ICS support nationally and funding identified • CEDAR Business Case FBC - bridging loan agreed • Capital Plan for 22/23 agreed by the Board as part of the Annual Financial Plan • Clinical Audit CA-19-0035 - Trust wide • Safeguarding Adults Audit. Good Practice • Internal Audit - CNTW 22-23 01 Risk Management & BAF	papers • NTW International recruitment competency documents • OPEL Framework documents • MDT Leadership advice and support available • All still in post and deployed across the Trust • The medical staffing team manage the medical recruitment function • Delivery of medical induction programme • CEDAR Business Case • Board papers and Capital Plan • Clinical Audit final report • Final report - Good level of assurance given	2. Addendum has been submitted and the Trust is currently engaged in responding to questions from NHP (KS)

Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 10	Risk that the Trust's information and systems is at higher risk of being compromised leading to unknown vulnerabilities. This could lead to loss of, and/or public disclosure of, information and loss of access to critical systems. SA4						
Strategic ambition	Sustainable for the long term, innovating every day	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Digital – cyber threats	16 (3 x 4)	16 (3 x 4) ⟷	16 (3 x 4) ⟷			8 (2 x 4)
Review date	20 September 2023						
Executive Lead	Kevin Scollay						
Lead Committee	Resources and Business Assurance Committee						

Context of the risk (narrative and background)	Gaps in control and/or assurance
Due to a more adversarial geopolitical environment, including the ongoing war in Ukraine, the rise of state-aligned groups from around the globe, and an observed rise in more aggressive cyber activity, it is highly likely cyber threats to the UK health sector will increase. The cybercrime threat to the UK health sector includes ransomware, phishing, commodity malware, data theft and extortion, cyber enabled fraud and Distributed Denial of Service, which are routinely seen across the sector. Of these threats, ransomware almost certainly remains the largest and most likely disruptive threat to the UK health sector, with cyber criminals taking advantage of the disruption caused to essential services for the purposes of extortion. It is likely cyber criminals view ransomware attacks against the health sector, especially hospitals and essential services, as particularly effective because of the time-critical nature of the services that can be disrupted. Cyber-attacks represent a threat to the confidentiality, integrity, robustness and capability of digital systems and services, and their associated use: • Access to electronic information prevented • Ability to effectively treat patients compromised • Timely capture of data prevented • External information unavailable to fulfil contractual requirements • Damage to reputation • Significant financial costs • Security Vulnerability	• Capacity within the Digital Services Team to provide dedicated resource to the management of potential cyber-threats. • Gap in reporting of assurance relating to cyber-threats within the Trust's governance framework.

Progress		
What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Malware email filters in place on MS Office 365 to block known malicious content along with anti-virus protection on machines that is updated daily. • MS Windows Enterprise facilities enabled such as AppLocker which blocks untrusted applications from running on end user devices • Trust managed laptops, PCs and servers are linked to NHS Data Security Centre MS Defender for End point service that continuously monitors devices for malicious behaviour. • External email configured with DMARC/DKIM sender authentication which blocks impersonation of emails from CNTW. • Immutable backups for critical data such as EPR system have been setup. • Systems patched via monthly process including internet browser to limit risk against known exploits. • Mandatory IG and Data Security training of staff to help promote identification of malicious emails and cyber security awareness. • Multi factor authentication of staff accessing Office 365 sensitive information which depends on the managed device they are using as well as any usernames and passwords that	• Evidence of malicious emails blocked available from Office 365 service. • Blocked applications can be evidenced from event logs that are pulled centrally. Service desk calls are raised by staff to unblock any legitimate applications that are not already centrally approved. • Emails are received from NHSE which provide evidence of number of systems communicating back to central service. Periodic emails raised with alerts from the centre that need further investigation. • External assessed annually via CIS benchmarking process needed for NHS Secure Email accreditation. • Recently implemented to supplier best practice, due to be audited 23/24 via AuditOne. • Recently audited via AuditOne for the Data Security and Protection Toolkit. • IG and Data Security training levels are measured and tracked annually to meet data security and protection toolkit compliance. • Evidence of blocked authentications can be shown via Office 365 reports. • Implementation has been externally assessed by AuditOne with a substantial assurance rating. • CREST accredited report	1. Upgrade Internet firewalls which provide additional capabilities such as blocking traffic based on country (GeoIP). Continue replacing Cisco ASA units with Cisco Firepower units. 2. Start deploying Windows 11 operating system across the organisation on new machines which has additional security features. Testing carried out on Windows 11 with further work needed to review apps and devices that are capable of running the system. 3. Recruit a new Cyber Security Analyst post for a dedicated resource to provide a more proactive approach to on-going cyber threats. A job description has been prepared. Awaiting funding approval to proceed to recruitment. 4. Clarify reporting arrangements for the provision of assurance relating to the management of cyber-risks.

they know. • Extra layers of authentication protection for privileged access to critical infrastructure which includes separate two factor authentication on data systems such as virtualisation platforms and critical network equipment. • Penetration tests carried out annually by CREST accredited independent auditors on Internet exposed services to help identify any potential exploitable systems.		

Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 11	Risk that the Trust does not deliver the objectives of its Green Plan affecting the physical and mental health of current and future generations. SA4						
Strategic ambition	Sustainable for the long term, innovating every day	**Residual rating**	**Q1 rating and movement**	**Q2 rating and movement**	**Q3 rating and movement**	**Q4 rating and movement**	**Target score**
Appetite category	Climate and Ecological Sustainability 12-15	20 (5 x 4)	20 (5 x 4) ⟷	20 (5 x 4) ⟷			12 (3 x 4)
Review date							
Executive Lead	Kevin Scollay						
Lead Committee	Resource and Business Assurance Committee						
Context of the risk (narrative and background)			**Gaps in control and/or assurance**				

Following a declaration in March 2020 of a climate and ecological emergency, the Trust recognised that climate and ecological change are affecting the physical and mental health of current and future generations. The Trust must **mitigate** further damage by adopting the principles of sustainable healthcare and reducing carbon emissions from activities in accordance with our Green Plan trajectories (net zero by 2040) and **adapt** our infrastructure and preparedness for increased likelihood of extreme weather events.	• Limited reporting on progress against the agreed Green Plan. • Clarity on the availability of capital funding. • Capacity issues within the team to progress the actions required against the Green Plan.

Progress		
What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Commitment to sustainable healthcare and net zero carbon emissions through Board Statement, Trust Green Plan, the new Trust strategy, 'with you in mind' and through the CNTW Climate Health programme. • Named CNTW Board lead for sustainability in place alongside Trust lead and trust clinical lead. NTW Solutions has sustainability included within its strategy and has created a new 'Energy and Low Carbon' manager. • Implementation of Trust Green Plan.	• Via Green Plan monitoring. • Via Green Plan monitoring. • Monitored through EMG and RABAC and inclusion on internal audit plan. • Monitored through business case processes.	1. Availability of capital funding to implement decarbonisation schemes. Make applications for new grant funding. Align Green Plan deliverables with existing capital funding availability. 2. Monitoring of Green Plan – new arrangements to be developed post Governance Review.

• Trust business cases include a requirement to articulate how the proposed change supports sustainable healthcare. • Influencing the mental health and learning disability sector re sustainable healthcare through the Green Minds Network and other opportunities.		3. Address resource issues within NTW Solutions. Proposal to be developed and taken to EMG for approval including the recruitment of longstanding vacant Energy Manager post.

Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

BAF RISK NUMBER 12	If the Trust does not consider its own position as a 'good partner', and the position of others as capable of working in partnership, there is a risk of that the Trust and the system does not allocate resource effectively, which may impact on the ability to deliver high quality, safe services across the system. SA5						
Strategic ambition	Working with, and for, our	**Residual**	**Q1 rating and**	**Q2 rating and**	**Q3 rating and**	**Q4 rating and**	**Target**

	communities	rating	movement	movement	movement	movement	score
Appetite category	Partnership working 16-25	12 (3 x 4)	12 (3 x 4) ⟷	12 (3 x 4) ⟷			8 (2 x 4)
Review date	20 September 2023						
Executive Lead	James Duncan						
Lead Committee	Executive Management Group						

Context of the risk (narrative and background)	**Gaps in control and/or assurance**
The Trust continues to work as a trusted system partner in the NENC ICS and place-based partnerships and arrangements. The Executive Team have established excellent working relationships with the Integrated Care Board and have in place, where appropriate, leadership roles for ICS-level programmes of work / workstreams. The ICS/ICB have a responsibility to develop their own strategic ambitions and priorities and it is important that this includes the strategic ambitions of the Trust. This is particularly in the context of: - Ensuring parity of esteem for MHLDA services across the footprint - Recognition that the Trust's strategic objectives cannot be achieved as a single organisation. - The priorities for the ICB and other providers across the system including the impact of the pandemic on service demand in all areas (including acute, ambulance and other health and care providers). - Recognition that the Trust's priorities in terms of its transformation plans reflect system-wide issues.	- Challenges relating to the Trust's geographic footprint and aligning this to current locality structures in terms of capacity to be present and influence system discussions. - Ensuring the Trust has a consistent narrative across all localities in terms of priorities and influence. - Complex governance structure at ICS level and assurance in terms of the voice of MHLDA at all levels.

Progress

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**	**What further actions do we need to take to address the gaps in control (including target dates for completion)**
• Trust representation on the NENC ICB	• Positive outcome following CNTW/NENC	• Development of a formal written report to

Board of Directors • Executive Leads identified for core work programmes / workstreams • Named individuals at Locality level representing the Trust at Place. • Strong relationships with third sector organisations.	ICB accountability meetings. • Increased involvement of the Trust in place-based activity and work.	the Board providing assurance of ICS/ICB working. • Review of Provider Collaborative governance arrangements including roles as responsibilities (providers, lead providers, commissioners).
Updates since last review		
New control	**New assurance**	**New actions**
N/A	N/A	N/A

4.0 Feedback from Board Committees – October 2023

The new BAF (from Q3 2023/24) risks were reviewed by each of the Board Committees at meetings held 25 October 2023. Feedback is as follows:

Mental Health Legislation Committee

The Committee held one risk relating to a risk of not meeting statutory and legal requirements relating to MHL. It was felt that because of the nature of the risk, this is managed efficiently via business-as-usual arrangements and the Committee to de-escalate the risk to the Medical Directors corporate risk register. In light of the ongoing management of risks relating to MHL and the low-level of associated risk, the Committee agreed not to incorporate any replacement risk in this regard in the new Board Assurance Framework.

People Committee

The Committee held one risk relating to the inability to recruit medical staff and agreed to close the risk and replace this with two risks relating to our ability to have a sustainable workforce plan in place to enable us to achieve our strategic ambitions and, a risk in relation to organisational culture and wellbeing.

Resource and Business Assurance Committee

The Committee agreed to close the existing risks associated with the Committee (section 2) and endorsed the new risks identified in the new BAF (section 3). It was agreed that the risk associated with proposals to take on new services either from another provider, or geography out-with the Trust's patch would be an issue for the Board as a whole and would require a thorough business case process. This risk is also linked to the new risk associated with the Executive Management Group in terms of working within, and our commitment to, the NENC Integrated Care System.

A discussion also took place regarding the current gap in assurance reporting for Digital risks, relating to cyber-threats and another, currently under development relating to Digital Solutions. Agreement was reached that Digital risks would be aligned to the Resource and Business Assurance Committee.

Quality and Performance Committee

The Committee agreed to close the existing risks associated with the Committee (section 2) and endorse the new risks identified in the new BAF (section 3). New risks include risks relating to ensuring a positive patient safety culture and learning reflected in the introduction of PSIRF and the need to ensure we learn from incidents, events, independent reviews etc., both within and out-with the organisation.

Provider Collaborative and Lead Provider Committee

Principal risks associated with the Committee will be considered in line with the current review of PC governance and role of the Board Committee.

5.0 Risk Appetite Statement

CNTW recognises that as a healthcare provider, risks will inevitably occur in the course of providing care and treatment to service users, supporting families and carers, employing staff, owning, leasing and maintain premises and equipment, managing finances and recognising the need for radical change in the context of the health and care system as it stands.

As a result, CNTW endeavours to establish a positive risk culture within the organisation, where unsafe practice is not tolerated and where every member of staff feels supported and empowered to identify, address, speak up out, and/or escalate system weakness.

The Board of Directors is committed to ensuring an effective risk management system, where risks are reported and managed at the lowest level of the organisation, as close to services as possible. The Trust also recognises that its long-term sustainability depends upon the delivery of its strategic ambitions, partnership working, and involvement from all stakeholders including service users, carers and the workforce.

The new risk appetite statement (below) has been developed with and endorsed by the Board it's the meeting held 20th September. This has been developed in the context of our current position as an organisation. There are 11 categories identified below, the main changes to highlight are:

- In relation to financial risk – the risk appetite has changed from MODERATE, to LOW risk appetite given the current financial challenges.
- The inclusion of Digital risks, workforce, model of care and innovation.
- Re-evaluating the risk appetite for Climate from LOW to MODERATE risk appetite recognising the reality of our ability to achieve our green plan in its entirety.

Risk Appetite Statement

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) 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, CNTW will not accept risks that materially provide an adverse impact on quality, safety, experience, and effectiveness.

However, CNTW has a greater appetite to take considered risks in terms of partnership working, and collaboration on organisational and system issues, and clinical innovation, 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
Quality (effectiveness and experience)	CNTW has a **LOW** appetite for risks that may compromise the delivery of outcomes, or risks that may affect the experience of, our service users.	**6-10**
Quality (safety)	CNTW has a **LOW** appetite for risks that may compromise safety.	**6-10**
Statutory and regulatory compliance	CNTW has a **LOW** appetite for risks which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**
Financial	CNTW has a **LOW** appetite for risks that impact on the possibility of financial loss and our ability to deliver care and treatment in the longer-term.	**6-10**

Digital – Cyber threats	CNTW has a **LOW** appetite for risks which may compromise the Trust's digital infrastructure.	**6-10**
Workforce/staffing	CNTW has a **LOW** appetite for risks associated with the Trust's workforce supply, skills and capacity and wellbeing within an appropriate culture.	**6-10**
Model of care	CNTW has a **MODERATE** appetite for risks associated with the development of the organisations model of care that does not compromise quality of care.	**12-15**
Estate infrastructure	CNTW has a **MODERATE** risk appetite for poor estates and infrastructure that may impact on our ability to deliver care in a safe environment.	**12-15**
Climate and Ecological Sustainability	CNTW has a **MODERATE** appetite for risks that may result in the harming of the environment which could lead to affect the physical and mental health of the populations we serve.	**12-15**
Innovation	CNTW has a **MODERATE** appetite for risks associated with clinical, non-clinical and digital innovation that does not compromise quality of care.	**12-15**
Partnership working	CNTW has a **HIGH** appetite for risks associated with working in partnership and collaboration across the NENC system which may support and benefit the people we serve.	**16-25**

6.0 Outstanding actions and next steps

6.1 Risk Management Strategy and Policy

Subject to approval of the new Board Assurance Framework and Risk Appetite at the November Board of Directors meeting, the new Risk Management Strategy and Policy will be issued for consultation during November in line with the Policy Management Process for submission to the December Board of Directors for approval and implementation. The Risk Management Policy includes clarity of the escalation process of risks from ward to Board.

6.2 E-Learning Package for Web Risk Training

In line with the review of the Risk Management Policy and clarity regarding escalation and management of risks in the organisation, an e-learning training package for all staff with responsibility for managing and reporting risks will be implemented. The e-learning package will be aligned to performance dashboards for reporting and assurance purposes. A request will also be considered as to making the training mandatory for Bands 7 and above where a risk register is an integral part of their role.

An internal communications plan will also be developed to support the implementation of the Risk Management Strategy, Risk Management Policy and associated support including the e-learning package.

6.3 Future Board Committee reporting

Subject to approval of the new BAF and Risk Appetite by the Board at its November meeting, a revised approach to Committee and Board reporting will be implemented to reflect alignment of Board and Committee business with key risks to the achievement of the Trust's strategic objectives.

7.0 Recommendation

The Trust Board are asked to:

- Note the changes and approve the closure of risks 1680; 1683; 1688; 1687; 1694; 1762; 1836 and 1853; 2041 contained in the existing BAF (up to and including Q2 2023/24) in the context of the development of the new BAF (from Q3 2023/24).
- Note Board Committee support of the above recommendation.
- Note the risks which have exceeded a risk appetite and be assured that the Board Committees have appropriate oversight of risks.
- Approve the new BAF risks (from Q3 2023/24).
- Approve the de-escalation of risk 1691 to the Medical Directorate Corporate Risk Register.
- Note and agree the new Trust Risk Appetite.
- Request further information on any significant risk management and assurance issues.

Executive Lead: Debbie Henderson, Director of Communication and Corporate Affairs
Report author: Yvonne Newby, Risk Management Lead
Date: 23 October 2023

21. BOARD COMMITTEE ANNUAL REVIEW AGAINST TERMS OF REFERENCE 2023

Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

21. Board and Committee Annual Review 2023.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**Board of Directors and Board Committee Terms of Reference Annual Review 2023**
Executive Lead	**Debbie Henderson, Director of Communications and Corporate Affairs**
Report author	**Debbie Henderson and Vicky Grieves, CQC Compliance Officer**

Purpose of the report	
To note	
For assurance	**X**
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	X
2. Person-led care, when and where it is needed	X
3. A great place to work	X
4. Sustainable for the long term, innovating every day	X
5. Working with and for our communities	X

Meetings where this item has been considered	
Quality and Performance	x
Audit	x
Mental Health Legislation	x
Remuneration Committee	x
Resource and Business Assurance	x
Charitable Funds Committee	x
People	x
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience	X	Service user, carer and stakeholder involvement	X
Board Assurance Framework/Corporate Risk Register risks this paper relates to			
N/A – in line with the requirements of the NHS statutory and regulatory framework			

Board of Directors and Board Committees
Terms of Reference and effectiveness Annual Review 2023

1. Executive Summary

In line with the requirements of the NHS statutory and regulatory framework, and to ensure the continuation of good governance, the Board of Directors and Board Committees are required to undertake an annual review of their Terms of Reference. The Terms of Reference were last reviewed and approved by the Board in December 2022.

All Board Committees, where appropriate, have completed a self-assessment against their Terms of Reference which have been reviewed at Committee level and are available on request. All Terms of Reference are attached for Board approval.

It should be noted that Terms of Reference and effectiveness review for:

- The Audit Committee was undertaken in June as part of the Annual Reporting process but are included here for completeness.
- The Provider Collaborative and Lead Provider Committee was undertaken at its last meeting held in September 2023. The Committee is currently monitoring this in the context of a wider review of PC governance arrangements.
- The Remuneration Committee was undertaken at its last meeting held in April 2023.

A common theme for all Committees (except for Remuneration Committee) as part of the 2023 review related to the process for induction to Committees for new members, including Governors. Currently an induction meeting is held with the Chair and new members, however, to further strengthen this process, a formal, detailed induction pack to each Committee will be developed by the Corporate Governance Team during Q4.

All Committees (except for Remuneration Committee) agreed to revert to the inclusion of subject experts as core members of the Committee to ensure appropriate assurance reporting. Revised membership is reflected in the terms of reference for Committees included in the paper.

	Committee	Change Since last approval
1	Board of Directors	No changes proposed.
2	Resource and Business Assurance	Amendments made to membership incorporating subject experts and locality representatives. Transfer of workforce and OD elements to People Committee.
3	Quality and Performance	Amendments made to membership incorporating subject experts and locality representatives.
4	Mental Health Legislation	Amendments made to membership incorporating subject experts and locality representatives. ***Note: the October meeting was not quorate***
5	Audit	No changes proposed.
6	Provider Collaborative and Lead Provider	Amendments made to membership incorporating subject experts and locality representatives.
7	People	Amendments made to membership incorporating recent changes to the structure of the Executive Team.
8	Remuneration	No changes proposed.
9	Charitable Funds	Inclusion of the newly established bid-review sub-group.

2. Recommendation
The Board is asked to:

- Approve the attached Terms of Reference for the Board of Directors and Board Committees outlined above.

Debbie Henderson
Director of Communications and Corporate Affairs/Company Secretary
November 2023

1. Board of Directors
Terms of Reference

Name	Board of Directors
Timing & Frequency	Board meetings will be held monthly in public. Closed Board meetings will be held monthly to discuss matters to be excluded from discussion in public in line with the Trusts Constitution. Meetings will not be held in January and June.
Admin support	Corporate Governance Manager
Reporting Arrangements	N/A
Membership	
Chair	Chair of the Board of Directors and Council of Governors
Deputy Chair	Vice-Chair
Members	Chief Executive All other Non-Executive Directors All Executive Directors of the Board
In Attendance	Director of Corporate Affairs and Communications and Company Secretary ***NB:*** *Other Trust representatives may attend meetings of the Board by invitation.*
Quorum	Five members to include a minimum of two Executive Directors and a minimum of three Non-Executive Directors.
Deputies	The Trust Vice-Chair to deputise for Trust Chair. Deputies are permitted to attend for Executive Directors for discussion only. Deputies have no voting rights. No deputies are permitted for Non-Executive Directors.

Purpose

The Board of Directors is collectively responsible for the exercise of powers and the performance of the NHS Foundation Trust *(the Trust)* and for the effective discharge of the Board's statutory duties. The general duty of the Board and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for members of the Trust as a whole and for the public.

The Trust should be led by an effective and diverse board that is innovative and flexible. The Boards role is to promote the long-term sustainability of the Trust as part of the ICS and wider healthcare system in England, generating value for members, patients, service users and the public. The Board should give particular attention to the Trust's role in reducing health inequalities in access, experience, and outcomes.

The Board will establish the Trust's vision, values and strategy, ensuring alignment with the ICP's Integrated Care Strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. All Directors must act with integrity, lead by example, and promote the desired culture.

The Board should ensure that the necessary resources are in place for the Trust to meet its objectives, including its contribution to the objectives agreed by the ICB and its partners, and measure performance against them.

The Board should establish a framework of prudent and effective controls that enable risk to be assessed and managed.

For the Trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the Board should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.

The Board should ensure that workforce policies and practices are consistent with the Trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The Board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

The Board should establish the Trust Constitution and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the Nolan principles.

The remainder of these Terms of Reference should be considered in the context of the principles of working within, and contributing to, the wider health and care system for the North East and North Cumbria.

Governance, rules and behaviours

Collective responsibility/decision making, arbitrated by the Chairman i.e. all members of the Board have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact on the particular responsibilities of the Chief Executive Officer as the Accounting Officer. In addition, all directors must take decisions objectively and in the best interests of the Trust and avoid conflicts of interest.

As part of their role as members of a unitary Board, all directors have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk, mitigation, values, standards and strategy. In particular NEDS should scrutinise (i.e. assess and assure themselves of) the performance of the Executive Management Team in meeting agreed goals and objects, receive adequate information and monitor the reporting performance, satisfying themselves as to the integrity of financial, clinical and other information, and make sure the financial and clinical quality controls, and systems of risk management and governance are robust and implemented.

Compliance with the Trusts Constitution, Standing Orders and NHS Code of Governance will be maintained.

All members are expected to attend-absenteeism is an exception.

Scope

The Board of Directors is responsible for:

- Ensuring the quality and safety of healthcare services, education, training and research delivered by the Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, NHS Improvement/NHS England, the Care Quality Commission and other relevant NHS bodies.
- Setting the Trust's strategy, vision, values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders within the ICS and wider health and care system are understood, clearly communicated and met. In developing and articulating a clear vision for the Trust, it should be a formally agreed statement of the Trust's purpose and intended outcome which can be used as a basis for the Trust's overall strategy, planning and other decisions.
- Ensuring compliance by the Trust with its licence, its Constitution, statutory and regulatory requirements and contractual obligations.
- Setting the Trusts strategic aims taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and then periodically reviewing progress and management performance.
- Ensuring that the Trust exercises its functions effectively, efficiently and economically.

Authority

Decision making in line with the authority outlined in these Terms of Reference, the Trust Constitution, Standing Orders, Scheme of Reservation and Delegation and standing Financial Instructions.

Deliverables

<u>Leadership</u>

- Implementation and communication of a clear organisational vision, purpose and goals
- Implementation of strategies to position the organisation as an excellent employer
- Establishment of effective Board and Committee structures, both internal and external
- Establishment of good governance, clear lines of reporting and accountability

<u>Culture, Ethics and Integrity</u>

- Set, implement, communicate and embed the organisational values
- Promote a patient centred culture of openness, transparency, and candour
- Maintain high standards of corporate governance and personal integrity in the conduct of business
- Application of appropriate ethical standards
- Establish appeals panel as required by employment policies
- Adherence of directors, staff and people working for, but not employed by, the Trust (i.e., Council of Governors, volunteers) to codes of conduct

Strategy

- Set and ensure delivery of the Trust's strategic purpose, goals and objectives
- Ensure alignment of strategic plans to the wider ICS, ICB and ICP strategies and aims
- Monitor and review management performance to ensure objectives are met
- Oversee the delivery of planned services and achievement of objectives
- Develop, maintain, and ensure delivery of the Trust's Annual Business Plan, having due regard to the views of the Council of Governors
- Have regard to, and implement where necessary, national policies and strategies

Quality

- Responsibilities for ensuring internal controls are in place for clinical effectiveness, quality of care, patient safety and experience
- Intolerance of poor standards and foster a culture which puts the patients first
- Engage with stakeholders, including staff and service users, on quality issues and ensure appropriate escalation and dealing with issues
- Responsible for the publication of the Trust's Annual Quality Account

Finance

- Ensure the Trust operates effectively, efficiently, economically
- Ensure continuing financial viability, both at Trust and system level
- Ensure resources are properly managed and financial responsibilities are delivered
- Review performance identifying opportunities for improvement
- Responsible for the publication of the Trust's Annual Accounts

Governance and Compliance

- Ensuring comprehensive governance arrangements are in place by complying with principles, standards, and systems of corporate governance having regard to NHS statutory and regulatory requirements, codes of conduct, accountability and openness
- Ensure compliance with all requirements of the Trust's Provider Licence conditions
- Ensure compliance with the Trust's Constitution.
- Formulate, implement, and review the Trust's Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation
- Ensure compliance with the requirements of the NHS Act, Health and Social Care Act, Mental Health Act and other legislative requirements
- Required returns and disclosures made to the regulators
- Ensure effective systems are in place for the appropriate appointment and evaluation arrangements for senior positions
- Responsible for the publication of the Trust's Annual Report and Accounts

Risk Management

- Ensure an effective system of integrated governance, risk management and internal control across all clinical and corporate activities
- Determine and agree the Trust's Risk Appetite and review on a regular basis
- Develop, monitor, and review the Trusts Board Assurance Framework and Corporate Risk Register and manage the risks to the achievement of the Trusts strategic objectives
- Oversee and monitor the implementation of the Trusts Risk Management Strategy and Policy

Communication, Engagement and Involvement

- Develop and maintain effective communication channels between the Board, Trust Governors, Trust members, members of staff and the local community
- Develop and maintain effective communication channels with key stakeholders and partners
- Work in partnership with the Council of Governors and ensure they are equipped with skills and knowledge needed to undertake their role
- Ensure effective dissemination of Trust wide information on service developments, strategies, plans, good practice and learning lessons
- Ensure effective strategies, systems and processes are in place for staff, service users and carer and stakeholder involvement in development of care plans, review of quality of services and development of new services
- Ensure compliance with statutory and regulatory requirements associated for formal consultation requirements

Sub Groups

The following Committees will report to the Board via submission of minutes of meetings supported by verbal updates from the Chair:

- Audit Committee (statutory committee)
- Remuneration Committee (statutory committee)
- Mental Health Legislation Committee (statutory committee)
- Quality and Performance Committee
- Resource and Business Assurance Committee
- Provider Collaborative Committee
- People Committee
- Charitable Funds Committee (committee of the Corporate Trustee)

Due to the confidential and sensitive nature of information concerning members of the Board of Directors, the Board shall receive a verbal summary of the Remuneration Committee meeting, where appropriate, rather than committee minutes.

Corporate Trustee
The Trust Board is regarded as having responsibility for exercising the functions of the Corporate Trustee. The Trust Board delegates these functions to the Charitable Funds Committee as a sub-committee of the Trust board, within any limits set out in the charitable funds section of Standing Financial Instructions and Scheme of Reservation and Delegation.

Current review date: November 2023
Date of previous Board approval: December 2022

2. Resource and Business Assurance Committee
Terms of Reference

Committee Name	Resource and Business Assurance Committee
Committee Type	Standing sub-committee of the Board of Directors
Frequency	Quarterly
Committee admin	Corporate Affairs Team
Reporting Arrangements	Minutes and report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive Director
Deputy Chair	Non-Executive Director
Members	Executive Director of Finance Chief Operating Officer Executive Director of Workforce and Organisational Development Chris Cressey, Deputy Director of Finance Locality Group Director Locality Group Medical Director Locality Group Nurse Director Governor representative x 2
In Attendance	Director of Communications and Corporate Affairs Matthew Lessell, Director of Estates, NTW Solutions Ltd
Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies required for all members and those in attendance

	No deputies are permitted for Non-Executive Directors

Purpose

Provide assurance to the Board that:

- The Trust has effective systems and processes in place to secure economy, efficiency and effectiveness in respect of all resources, supporting the delivery of the Trust's Strategy and Operational Plans.
- There is a clear understanding of current and emerging risk to that delivery and that strategic risk in relation to the effective and efficient use of resources and the long term sustainability of the Trust and its services are being managed.

Scope

- Review of arrangements for the development of the Trust Annual Resource Plan, ensuring that resources are adequately identified to meet quality and performance standards, or to highlight appropriate risks to the board
- Oversee the assurance delivery against the Trust's annual resource plan and the impact of in year delivery on key financial strategic risk.
- Oversee arrangements for financial reporting, cash management, internal control and business planning to ensure that they comply with statutory, legal and compliance requirements and that they are developing towards best practice. Ensure that that there is a clear understanding of current and emerging risks and that actions are in place to maintain and continually improve the organisation's position as a high performing Trust for the use of resources.
- Oversee and assure the Trust's delivery of the Capital Programme in the light of service development plans, risk and quality issues, and in line with the Trust's Strategy and Operational Plans and the management of strategic risks.
- Oversee and assure arrangements for managing contractual relationships with Commissioners of services and ensure that there is a clear understanding of current and emerging risks.
- To oversee the development of significant investment and development proposals on behalf of the Board of Directors, including major projects, business case development, and tenders. Also to receive assurance on effective financial modelling for major tenders, effective project implementation and post project evaluation.
- Oversee and assure arrangements relating to the review the Trust's Commercial Investment Policy and Innovations Strategy.
- To receive assurance that proper arrangements are in place for the procurement of goods and services and that there is a clear understanding of current and emerging risks.
- To receive assurance that proper arrangements are in place for the management of the Trust's estate and that the infrastructure, maintenance and developmental programme supports the Trust's Strategy, Operational Plans and legal and statutory obligations. Ensure that there is a clear understanding of current and emerging risks.
- To receive assurance on the Trust delivery against its Green Plan and its overall response to the Climate and Ecological Emergency
- To receive assurance that proper arrangements are in place for the management of the Trust's Information Technology and Infrastructure, maintenance and development programme ensuring it supports the Trust's Strategy and Operational Plans, including delivery of improvement and efficiency objectives, and the fulfilment of legal and statutory obligations. Ensure that there is a clear understanding of current and emerging risks.
- To receive assurance that proper arrangements are in place to ensure delivery of sustainable healthcare, with a focus on productivity, benchmarking and the shift to early

intervention and prevention

- To receive assurance that cash investment decisions are made in line with the Treasury Management Policy, and to review changes to this Policy, where appropriate.
- To receive assurance that appropriate arrangements are in place for insurance against loss across all Trust activities.
- Receive for assurance purposes routine reports from all standing sub groups and any other relevant reports/action plans in relation to current issues.
- Contribute to the maintenance of the Trust's Corporate Risk Register and Board Assurance Framework by ensuring that the risks that the Resource and Business Assurance Committee are responsible for are appropriately identified and effective controls are in place and that strategic risk in relation to the effective and efficient resources, and the long term sustainability of the Trust and its services are being managed.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
  - Review the management of the Corporate Risk Register and the Groups top risks;
  - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks;
  - Report to the Board of Directors on any significant risk management and assurance issues.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

Deliverables

Assurance to the Board that:

- Effective systems and processes are in place to deliver the Trust's Financial Strategy and targets (including the Trust's capital resources) and that there is a clear understanding of current and emerging risk to that delivery.
- Effective systems are in place to deliver against the Trusts Green Plan.
- Effective systems and processes are in place to ensure the Trust's delivery against specific aspects of the Trust's Workforce Strategy/performance standards ensuring that the Trust has the workforce resources and capacity to deliver the Trust's Strategy and Operational Plans and that there is a clear understanding of current and emerging risk to that delivery.
- Effective systems and processes are in place to ensure that legislative, mandated (eg CQC, CQIN).
- Effective systems and processes are in place to manage commercial activity and business development, in line with the Trust's Strategy, Operational Plans, Trust policies and Monitor requirements, including major projects, business case development, tendering and post project evaluation arrangements and that there is a clear understanding of current and emerging risks.
- Effective systems and processes are in place for managing contractual relationships with Commissioners of services and that there is a clear understanding of current and emerging risks.
- Effective systems and processes are in place for the procurement of goods and services and that there is a clear understanding of current and emerging risks.
- That Estates and Information Technology infrastructure, systems and processes are designed, delivered and maintained to support the delivery of the Trust's Strategy and

Operational Plans and that there is a clear understanding of current and emerging risks. • The risks, that the Resource and Business Assurance Committee are responsible for, are appropriately identified and effective controls are in place and that strategic risk in relation to the effective and efficient resources, and the long term sustainability of the Trust and its services are being managed.
Sub Groups
Links to Trust Leadership Team Operational Groups
Date of Committee Review: October 2023 **Date of Board approval: November 2023** **Date of previous Board approval: December 2022**

3. Quality and Performance Committee Terms of Reference

Committee Name	Quality and Performance Committee (Q&P)
Committee Type	Standing sub-committee of Board of Directors
Frequency	Eight times a year
Committee admin	CQC Compliance Officer
Reporting Arrangements	Minutes and Report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive
Deputy Chair	Non-Executive
Members	Chief Operating Officer Executive Director of Nursing, Therapies and Quality Assurance Executive Medical Director Executive Director of Workforce and Organisational Development Executive Director of Finance Other Non-Executive Directors Governor representatives x 2 Deputy Chief Operating Officer Deputy Director of Nursing Director of AHPs and Psychological Services Chief Pharmacist Locality Group Director representative Locality Group Medical Director representative Locality Group Nurse Director representative
In Attendance	Director of Communications and Corporate Affairs as appropriate Associate Director of Involvement and Lived Experience

	Deputy Director of therapies Deputy Director of Psychological Services Head of Performance Delivery
Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies required for all members and those in attendance No deputies are permitted for Non-Executive Directors

Purpose

Provide assurance to the Board that:

- The Trust has effective systems and processes in place for the management of risks pertaining to their area of focus, safety quality and performance across the Trust.
- The Trust has an effective Assurance/Performance Framework.
- The Trust complies with the law, best practice, governance and regulatory standards which are within the Committee's scope.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

Deliverables

Assurance to the Board re:

- The successful implementation of key quality and performance strategies, programmes of work and systems.
- That there is an effective risk management system operating across the Trust including Group Risk Registers, a Corporate Risk Register and Board Assurance Framework which provides assurances to the Board that effective controls are in place to manage corporate risks.
- The Trust's action plans in relation to compliance and legislative frameworks are robust and completed/signed off, with the exception of areas covered by the Resource and Business Advisory Committee and Mental Health Legislation Committee.
- The implementation of NICE Guidance and other nationally agreed guidance are the main basis for prioritising Clinical Effectiveness.
- The Trust's continued compliance with the CQC's Fundamental Standards.
- Compliance against the Coroners Amended Rules 2008.
- Standards of care, compliance with relevant standards and quality and risk arrangements in each Operational Group.
- That information from patient and carer experience, including themes and trends, is informing service improvement.
- That information from staff experience, including themes and trends, is informing service improvement.
- The operation of all standing sub groups and delivery of any relevant reports/action plans in relation to current issues.
- The management and use of Controlled Drugs within the Trust and across the local prescribing interface with the statutory Local Intelligence Network.
- The Committee has links to relevant service user/carer and Governor Forums.
- Effective systems and processes are in place with regard to clinical audits and Board Assurance Framework audits including robust processes to ensure recommendations and action plans are completed.
- The risks, that the Quality and Performance Committee are responsible for, are appropriately identified and effective controls are in place.

Sub Groups
Health, Safety and Security Positive and Safe Emergency Preparedness, Resilience and Response Caldicott Information Governance Medicines Optimisation Committee Clinical Effectiveness Committee Research Governance Oversight Group Safeguarding and Public Protection Physical Health and Wellbeing Infection, Prevention and Control Patient and Carer Experience Group Quality Standards Also links with: Council of Governors' Quality Group, Executive Management Group and CQC Quality Compliance Group
Date of Committee Review: October 2023 **Date of Board approval: November 2023** **Date of previous Board approval: December 2022**

4. Mental Health Legislation Committee
Terms of Reference

Committee Name	Mental Health Legislation Committee
Committee Type	Standing sub-committee of Board of Directors
Frequency	Quarterly
Committee admin	Corporate Affairs Team
Reporting Arrangements	Minutes and report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive Director
Deputy Chair	Non-Executive Director
Members	Executive Medical Director Executive Director of Nursing, Therapies and Quality Assurance Chief Operating Officer Other Non-Executive Directors Associate Director Information Governance and Mental Health Legislation Locality Group Director representative Locality Group Medical Director representative Locality Group Nurse Director representative Group Medical Director (Chair of the Mental Health Legislation Steering Group) Governor Representatives x 2
In Attendance	Director of Communications and Corporate Affairs Representatives of Mental Health Legislation Team
Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies required for all members and attendees

	Named deputies for Executive Directors will be accepted No deputies are permitted for Non-Executive Directors

Purpose

Provide assurance to the Board that:

- There are systems, structures and processes in place to ensure compliance with and support the operation of Mental Health Legislation within inpatient and community settings, and to ensure compliance with associated code of practice and recognised best practice.
- The Trust has in place and uses appropriate policies and procedures in relation to Mental Health Legislation and to facilitate the publication and guidance of the legislation to all relevant staff, service users, carers and managers.
- Hospital Managers and appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health and associated legislation.

Scope

- Ensure the formulation of Mental Health Act Legislation Steering Group and receive quarterly assurance reports on the Mental Health Legislation Steering Group's activities in relation to activities.
- Keep under review annually the Trusts "Delegation of Statutory Functions under the Mental Health Act 1983" policy including the Schedule of Delegation appended to that policy.
- Receive and review the Mental Health Legislation Activity and Monitoring Report (MHA Code of Practice requirements), this includes:
    - Emergency applications for detention (Section 4 & 5)
    - Emergency treatment (Section 62 & 64)
    - CTO recalls (Section 17E & Section 17F)
    - Mental Health Tribunal referrals
- Receive assurance from the Mental Health Legislation Steering Group that the Trust is compliant with legislative frameworks and that there are robust processes in place to implement change as necessary in relation to Mental Health legislation and report on ongoing and new training needs.
- Receive the results in relation to the monitoring of policies linked to the Mental Health Act and Mental Capacity Act legislation and monitor any associated action plans.
- Consider and recommend the Annual Audit Plan in relation to Mental Health Legislation.
- Receive assurance that new law guidance and best practice is disseminated and actioned appropriately.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
    - Review the management of the Corporate Risk Register and the Groups top risks;
    - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks;
    - Report to the Board of Directors on any significant risk management and assurance issues.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place with regard to those areas within the Committee's scope across the organisation.

Deliverables

Assurance to the Board re:

- The effective implementation of Mental Health Legislation within inpatient and community

settings and compliance with associated Codes of Practice.

- The necessary policies and procedures in relation to mental health legislation are in place, updated and reviewed in line with legislative changes.
- The Trust's "Delegation of Statutory Functions under the Mental Health Act 1983" policy including the Schedule of Delegation appended to that policy, is reviewed annually.
- The Trust's compliance with requirements of the Mental Health Act and Mental Capacity Act Codes of Practice in respect of the mental health legislation and activity and monitoring reports.
- Compliance with and the effective implementation of Mental Health Legislation and that robust processes are in place to implement change as necessary in relation to Mental Health Legislation and reporting on ongoing and new training needs.
- Effective systems and processes are in place in respect of the monitoring of policies linked to the Mental Health Act and Mental Capacity Act legislation including robust processes to ensure recommendations and action plans are completed.
- Effective systems and processes are in place in respect of the dissemination and auctioning of new law guidance and best practice.
- The risks that the Mental Health Legislation Committee is responsible for are appropriately identified and effective controls are in place.
- Recommend the Annual Audit Plan in relation to Mental Health Legislation to the Audit Committee.

Sub Groups

Mental Health Act Legislation Steering Group
Any other task and finish subgroups associated with the business of the Committee

Date of Committee review: October 2023
Date of Board approval: November 2023
Date of previous Board approval: December 2022

5. Audit Committee
Terms of Reference

Committee Name:	Audit Committee
Committee Type:	Statutory committee of the Board of Directors
Timing & Frequency:	The committee will meet a minimum of five times per year but may meet more frequently at the discretion of the Chair.
Committee Secretary:	Corporate Governance Manager
Reporting Arrangements:	The committee will report to the Board of Directors via submission of minutes and an Annual Report in April/May each year.
Membership	
Chair:	Non-Executive Director
Deputy Chair:	Non-Executive Director
Members:	Three Non-Executive Directors (including the Chair and Vice-Chair)
In Attendance:	- Executive Director of Finance - Director of Corporate Affairs and Communications/Company Secretary - Managing Director for NTW Solutions Ltd - Internal Auditors (AuditOne) - Local Counter Fraud Services - External Auditors - Governor representative X 2 *Executive Directors and other Trust representatives will be expected to attend meetings at the request of the Chair* *The Chief Executive should also attend when discussing the draft Annual Governance Statement and the Annual Report and Accounts.*
Quorum:	Three members (to include a minimum of one Non-Executive Director and one Executive Director of the Trust)

Deputies:	Deputies are permitted to deputise for those in attendance No deputies are permitted for Non-Executive Directors

Purpose

To provide assurance to the Board of Directors that effective internal control arrangements are in place for the Trust and its subsidiary companies. The Committee also provides a form of independent scrutiny upon the executive arm of the Board of Directors. The Accountable Officer and Executive Directors are responsible for establishing and maintaining processes for governance. The committee independently monitors, reviews and reports to the Board of Directors on the process of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

Governance, rules and behaviours

The committee is authorised by the Board of Directors:

- To investigate any activity within its Terms of Reference
- To obtain outside legal or other independent professional advice and secure attendance of outsiders with relevant experience and expertise it considers necessary
- Ensure that the Head of Internal Audit, representatives of External Audit and Counter Fraud specialists have a right of access to the Chair of the committee
- Ensure compliance with Monitor's Code of Governance and NHS Audit Committee Handbook

Scope

Integrated Governance, Risk Management and Internal Control

Oversee the risk management system and obtain assurances that there is an effective system operating across the Trust. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust and Subsidiary Companies that supports the achievement of the organisations objectives. In particular the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (i.e., the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors
- The underlying assurance processes that indicates the degree of achievement of the organisation's objectives and the effectiveness of the management of principal risks.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certification
- The policies and procedures for all work related to fraud as required by NHS Protect
- The work of Internal Audit, External Audit, local Counter Fraud Specialists and other assurance functions. It will also seek reports and assurances from directors and managers as appropriate
- The development, monitoring and review of the Trust's Board Assurance Framework
- The committees relationships with other key Committees to ensure triangulation of issues relating to risk management and clinical and quality issues

Internal Audit

Ensuring an effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

- Consideration of the provision of the Internal Audit function and the costs involved
- Review and approval of the Internal Audit Plan, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework
- Consideration of the major findings of Internal Audit work and ensuring co-ordination between the Internal and External Auditors
- Ensuring that the function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

Counter Fraud

Ensuring adequate arrangements are in place for countering fraud and reviewing the outcomes of counter fraud work. This will be achieved by:

- Consideration of the provision of the counter fraud function and the costs involved
- Review and approval of the counter fraud strategy, annual work plan and the three year risk based local proactive work plan
- Consideration of the major findings of counter fraud proactive work, review of progress against plans and the annual report on arrangements
- Ensuring that the function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of the counter fraud function and carrying out an annual review, taking into account the outcome of the NHS Protect quality assessment of arrangements

External Audit

The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular review the work and findings of the external auditors and consider the implications and management responses to their work. This will be achieved by:

- Discussion and agreement with the External Auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and impact on the audit fee
- Reviewing all reports, including the reports to those charged with governance arrangements, including the annual management letter before submission to the Board of Directors and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Supporting the Council of Governors with their duty to appoint, re-appoint and remove the External Auditors as stipulated by Monitor's Code of Governance
- Develop and implement a policy, with Council of Governors approval, that sets out the engagement of the External Auditors suppling non-audit services. This must be aligned to relevant ethical guidance regarding the provision of non-audit services by the External Audit firm

Other Assurance Functions

Review the findings of other significant assurance functions, both internal and external to the organisation, and consider governance implications. These will include, but will not be limited to:

- Reviews by the Department of Health Arm's Length Bodies or regulators/inspectors (e.g. CQC, NHSLA, etc.) and professional bodies with responsibility for the performance of staff or functions

(e.g. Royal Colleges, accreditation bodies, etc)

- Review the work of other committees within the Trust at its Subsidiary Companies, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include the committee with the remit for clinical governance, risk management and quality
- In reviewing the work of the aforementioned committees, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function

Management

Request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. Request specific reports from individual functions within the organisation.

Financial Reporting

Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.
Review the Trust's internal financial controls and review the Annual Report and financial statements before submission to the Board of Directors, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted miss-statements in the financial statements
- Significant judgements in preparation for financial statements
- Letter of representation
- Explanation for significant variances

Quality Accounts

Review the draft Quality Accounts before submission to the Board of Directors for approval, specifically commenting on:

- Compliance with the requirements of the NHS Reporting Manual
- The findings and conclusion of limited assurance report from the External Auditor
- The content of the Governors' report to Monitor and the Council of Governors
- Supporting controls e.g. data quality, if appropriate

Whistle blowing

The committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that such concerns are investigated proportionately and independently.

The Audit Committee Annual Report should describe how the committee has fulfilled its delegated responsibilities outlined in its Terms of Reference, and a summary following a review of its own effectiveness. It will also provide details of any significant issues that the committee considered in relation to the financial statements, key risks and how they were addressed along with other responsibilities specified in Monitor's Code of Governance.

Monitoring

The Committee will review its performance annually against its Terms of Reference and will report on the outcomes in its annual report to the Board.

Authority

The Committee independently reviews subjects within its Terms of Reference, primarily by receiving reports from the external auditor, internal auditor, local counter fraud specialist, management and any other appropriate assurances.

Deliverables

Assurance to the Board re:

Integrated Governance, Risk Management and Internal Control
The establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisations objectives.

Internal Audit
An effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Audit Committee, Chief Executive and Board of Directors.

Counter Fraud
That the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

External Audit
External Auditor's independence and objectivity and the effectiveness of the audit process.

Other Assurance Functions
The findings of other significant assurance functions, both internal and external to the organisation and the implications for the governance of the organisation are considered. That the work of other Committees within the organisation provide relevant assurance to the Audit Committee's own areas of responsibility. The clinical audit functions effectiveness in terms of providing assurance regarding issues around clinical risk management.

Management
The overall arrangements for governance, risk management and internal control, having regard to evidence and assurances provided by directors and managers and specific reports from individual functions within the organisation (e.g. clinical audit).

Financial Reporting
The integrity of financial statements, systems for financial reporting, internal financial controls, the Annual Report and financial statements, including the wording of the Annual Governance Statement.

Annual Report and Accounts (including the Quality Account)
The draft Annual Report and Accounts (including the Quality Account) before submission to the Board of Directors for approval.

Whistle blowing
Effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and subsequent investigations.

Reporting
An Annual Report will be presented to the Board of Directors on its work in support of the Annual Governance Statement.

Sub Groups
There are no sub-groups of the Audit Committee
Current review date: June 2023 **Date of Board approval: June 2023** **Date of previous review: June 2022**

6. Provider Collaborative Lead Provider Committee (PCLP) Terms of Reference

Committee Name	Provider Collaborative and Lead Provider Committee (PCLP)
Committee Type	Standing sub-committee of Board of Directors
Frequency	Quarterly
Committee admin	Corporate Affairs Team
Reporting arrangements	Minutes and Report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive Director
Deputy Chair	Non-Executive Director
Members	Executive Director of Finance Executive Director of Nursing, Therapies and Quality Assurance Chief Operating Officer Other Non-Executive Directors Governor representatives x 2 Associate Director of Contracting Associate Director Provider Collaboratives
In Attendance	Director of Communications and Corporate Affairs as appropriate Group Director Secure Services Group Director Children and Young People's Services
Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies Required for all members

	No deputies are permitted for Non-Executive Directors

Purpose

Provide assurance to the Board that:

- The Trust has effective systems and processes in place for the management of risks pertaining to Provider Collaborative and Lead Provider Models.
- The Trust has an effective management of Provider Collaborative and Lead Provider Contracts, including the sub-contracts of the lead provider contracts and any partnership agreements.
- The Trust complies with the law, best practice, governance and regulatory standards which are within the Committee's scope.

Scope

- Oversee and assure the successful delivery of Provider Collaborative and Lead Provider Models, including the sub-contracts of the lead provider contract. In accordance with the business cases and agreements reached by the Board of Directors.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
    - Review the management of the Corporate Risk Register and the Groups top risks.
    - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks.
    - Report to the Board of Directors on any significant risk management and assurance issues.
- Gain assurance that the Trust's action plans in relation to compliance and legislative frameworks, which are within the scope of the Committee, are robust, completed and signed off.
- Gain assurance that each contract is managed and that there are effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, financial, risk and assurance arrangements.
- On behalf of the Board of Directors provide assurance that the financial and quality risks are articulated, evaluated and managed.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

Deliverables

Assurance to the Board re:

- The successful implementation and management of Provider Collaborative and Lead Provider models across the Trust.
- The Trust's action plans in relation to compliance and legislative frameworks are robust and completed/signed off, within the scope of this committee.
- The risks, that the Provider Collaborative and Lead Provider Committee are responsible for, are appropriately identified and effective controls are in place.

Subgroups

PCLP Quality Group
PCLP Commission/Contracting Group
PC Partnership Board minutes to be received by committee

Date of Committee review: October 2023 **Date of Board approval: November 2023** **Date of previous Board approval: December 2022**

7. People Committee
Terms of Reference

Committee Name	People Committee
Committee Type	Standing sub-committee of Board of Directors
Frequency	Quarterly
Committee admin	Corporate Affairs Team
Reporting arrangements	Minutes and Report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive Director
Deputy Chair	Non-Executive Director
Members	Executive Director of Workforce and Organisational Development Executive Director of Nursing, Therapies and Quality Assurance Executive Medical Director Chief Operating Officer Executive Director of Finance One other Non-Executive Director (excluding Chair and Vice-Chair) Deputy Director of Workforce and Organisational Development Locality Group Director Locality Group Medical Director Locality Group Nurse Director Governor representatives x 2
In Attendance	Director of Communications and Corporate Affairs Chris Rowlands, Equality, Diversity and Inclusion Lead Emma Lovell, Associate Director of Organisational Development Claire Vesey, Head of Workforce Development

Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies required for all members by exception and with prior agreement of the Chair No deputies are permitted for Non-Executive Directors

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

1. Assurance to the Board will be via:
2. The successful implementation of the Workforce Strategy, enabling strategies and underpinning programmes and plans.
3. Effective management of risk relating to the workforce portfolio providing assurances to the Board that effective controls are in place to manage workforce risks.
4. Delivery of the Trust's action plans in relation to compliance, legislative and regulatory requirements relating to workforce.

5. The implementation of the requirements of the NHS People Plan and other nationally agreed guidance.
6. Compliance with relevant standards and key performance indicators relating to workforce.
7. 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.
8. Feedback from other internal workforce forums.
9. Progress of identified work from all standing sub-groups and delivery of any relevant programmes and plans.
10. Feedback from staff Networks where appropriate.
11. Ongoing progress on developing the organisational offer to support health and wellbeing programme and plans and providing assurance on the benefits of such schemes.
12. Updates on the Trust Academy Programme and its contribution to the wider workforce strategy and organisational development plans.
13. 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.

Date of Committee review: October 2023
Date of Board approval: November 2023
Date of previous Board approval: December 2022

8. Remuneration Committee
Terms of Reference

Committee Name:	Remuneration Committee
Committee Type:	Statutory Sub Committee of the Trust Board
Timing & Frequency:	A minimum of one meeting to be held per year, however, meetings can be held more frequently as required by the Chair
Committee Secretary:	Director of Corporate Affairs and Communications
Reporting Arrangements:	Due to the confidential and sensitive nature of information concerning members of the Board of Directors, the Board shall receive a verbal summary of the committee meeting, if deemed appropriate (rather than committee minutes).
Membership	
Chair:	Chairman of the Council of Governors and Board of Directors
Deputy Chair:	Vice-Chair
Members:	All Non-Executive Directors
In Attendance:	Chief Executive (advisory capacity only) Executive Director of Workforce and OD (advisory capacity only) Director of Corporate Affairs and Communications (advisory capacity only) ***NB:*** *The Chief Executive and other Executive Directors shall not be in attendance when their own remuneration, terms and conditions are discussed but may, at the discretion of the Committee attend to discuss the terms of other staff.*
Quorum:	Four members
Deputies:	The Vice-Chair to deputise for Chair but no deputies are permitted for Non-Executive Directors.
Purpose	

To decide and review the remuneration, terms and conditions of office of the Foundation Trust's Executive Directors and comply with the requirements of NHS England's Code of Governance and any other statutory requirements.

To decide and review the remuneration, terms and conditions of office of the Trust Board Directors of the Trust's subsidiary companies.

Governance

- Meeting business can be agreed via email at the discretion of the Chair and to expedite decision making where appropriate.

Scope

To decide and review the remuneration, terms and conditions of office of the Foundation Trust's Executive Directors and comply with the requirements of NHS England's Code of Governance and any other statutory requirements.

To review the arrangements for local pay (Band 8C and above) in accordance with national arrangements for such members of staff where appropriate.

To decide and review the terms and conditions of office for the Board Directors of NTW Solutions.

Authority

Decision making in line with the delegated authority outlined in these terms of reference.

Deliverables

Decide upon, after taking appropriate advice and considering benchmarking data, appropriate remuneration and terms of service for the Chief Executive, Executive Directors employed by the Trust and Board Directors of the Trust's subsidiary companies including:

- All aspects of salary (including any performance related elements/bonuses),
- Provisions for other benefits including pensions and cars;
- Arrangements for termination of employment and other contractual terms.

In addition, the Remuneration Committee will review the arrangements for local pay (Band 8C and above) in accordance with national arrangements for such members of staff where appropriate.

Ensure that remuneration and terms of service of Executive Directors takes into account their individual contribution to the Trust, having proper regard to the Trusts circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of national guidance.

Receive a report on the outcomes of the appraisals for the Executive Directors from the Chief Executive.

Ensure compliance with NHS England's Code of Governance by taking the lead on behalf of the Board of Directors on:

- The Board of Directors shall not agree to a full time Executive Director taking one or

more Non-Executive directorship of an NHS Foundation Trust or any other organisation of comparable size and complexity, nor the chairmanship of such an organisation.

- The Remuneration Committee should not agree to an Executive Director member of the Board leaving the employment of an NHS Foundation Trust, except in accordance with the Terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.

Ensure compliance with NHS England's Code of Governance relating to the appointment of Executive Directors and the appointment and removal of the Chief Executive.

- The Chairman and other Non-Executive Directors and (except in the case of the appointment of a Chief Executive) the Chief Executive, are responsible for deciding the appointment of Executive Directors, i.e. all Executive Directors should be appointed by a committee of the Chief Executive, Chairman and Non-Executive Directors.

- It is for the Non-Executive Directors (including the Chairman) to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.

- The roles of the Chairman and Chief Executive must not be undertaken by the same individual.

Ensure compliance with the requirements of "NHS Employers: Guidance for employers within the NHS on the process for making severance payments".

- Prior to receiving agreement to make a special severance payment from Monitor and before presenting a paper to the HM Treasury for approval, the Trust must follow the steps outlined in the guidance and be satisfied that termination of the employees employment, together with making a severance payment, is in the best interests of the employer and represents value for money. The Remuneration Committee should consider the proposal which should contain a Business Case for the severance payment.

- The Remuneration Committee's role is to:

    - Satisfy itself that it has the relevant information before it, to make a decision.
    - Conscientiously discuss and assess the merits of the case.
    - Consider the payment or payment range being proposed and address whether it is appropriate taking into account the issues set out under initial considerations. The Committee should only approve such sum or range which it considers value for money, the best use of public funds and in the public interest.
    - Keep a written record summarising its decision (remembering that such a document could potentially be subject to public scrutiny in various ways, for example by the Public Accounts Committee).
    - Seek external advice, to be arranged via the Director of Communications and Corporate Affairs, where appropriate and as agreed by the Chair

Sub Groups

No Sub Groups

Links to other sub-committees/forums

Reports directly to the Board of Directors

Current review date: April 2023 **Date of Board approval: November 2023** **Date of previous review: June 2022**

9. Charitable Funds Committee
Terms of Reference

Committee Name:	Charitable Funds Committee
Committee Type:	Statutory Sub Committee of the Corporate Trustee *(CNTW Board of Directors)*
Timing & Frequency:	Meetings will be held quarterly, however meetings can be held more frequently as required by the Chair
Committee Secretary:	Executive Assistant
Reporting Arrangements:	The Committee will report into the Corporate Trustee (CNTW Board) on a quarterly basis.

Membership	
Chair:	Non-Executive Director
Deputy Chair:	Non-Executive Director
Members:	Executive Director of Finance Executive Director of Nursing, Therapies and Quality Assurance Patients Finance and Cashiers Manager Head of Accounting and Processing Director of Communications and Corporate Affairs Marketing Manager Governor representative x 2
In Attendance:	Other Trust representatives may be invited to attend at the request of the Chair
Quorum:	Four members to include: - At least one Non-Executive Director (including the Chair) - At least one Executive Director Decisions will be made by a majority vote. In circumstances where the vote is tied, the Chair of the meeting will have a second and casting vote.

Deputies:	The Vice-Chair to deputise for Trust Chair but no deputies are permitted for Non-Executive Directors.

Purpose

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Charity is registered with the Charity Commission with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust as the Corporate Trustee (as a unitary Board of Directors).

The aim of the Charitable Funds Committee is to undertake the routine management of the Charity, in accordance with the Trust's Scheme of Delegation, and to give additional assurance to the Corporate Trustee that the Trust's charitable activities are within the law and regulations set by the Charity Commission for England and Wales. It does not remove from the Corporate Trustee the overall responsibility for stewardship of Charitable Funds but provides a forum for a more detailed consideration and management of all charitable activity within the Trust.

Scope and duties

Specific duties of the Charitable Funds Committee include:

- The day-to-day management of the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Charity (CNTW Charity) on behalf of the Corporate Trustee.
- Ensure the Charity complies with current legislation and regulation.
- Review new legislation, regulation and guidance and its impact on the Charity, making recommendations to the Corporate Trustee if changes in practice or policy is required.
- Review and approve any returns and information required to be submitted by legislation to the regulator, the Department of Health or the Charity Commission.
- Oversee the implementation, update and maintenance of procedures and policies required to ensure the efficient and effective operation of the Charity and in accordance with Charity Commission guidance.
- Develop an overarching Charity Strategy and supporting plans including setting spending targets, budgets, fundraising and investment, ensuring plans are in line with the objectives of the Charity.
- Ensure a robust governance framework is in place to support the day to day management of the Charity, delivery of the Charity strategy and compliance with associated policies and procedures.
- Seek assurance that investments are in compliance with the Charity's investment policy and make recommendations to the Corporate Trustee if changes are proposed.
- Determine the management arrangements for the Charity's investments and review performance regularly against agreed benchmarks;
- Review the policy for expenditure of funds including the use of investment gains;
- To approve all individual charitable fund expenditure and proposals for expenditure. The Committee has authority to seek approval via email with ratification of all decisions at the next meeting;
- Review individual fund balances within the overall charitable funds on a regular basis, seek expenditure plans from individual fund holders and oversee expenditure against the charitable funds in accordance with the Scheme of Delegation;
- Agree guidance and procedures for the fund holders and ensure they are publicised to those who need to be aware of them;
- Receive and review the Annual Accounts and Annual Reports for the Charity and submit them to the Corporate Trustee for approval;
- Review and act on any internal and/or external audit recommendations;

- Encourage a culture of fund raising within the Trust, raise the profile of the Charity and monitor progress of the Charity Strategy;
- Receive regular reports on the performance of fundraising activities for the Charity;
- Approve the policy and standards around promotion of the Charity on behalf of the

Corporate Trustee to ensure that material does not endanger the Charity's reputation.

Authority

The Committee is authorised by the Corporate Trustee. Decision making is in line with the delegated authority outlined in these terms of reference.

In line with the Scheme of Delegation, any requests for disbursement of monies from general funds, and disbursement from individual funds of more than £1000 will require approval by Committee members. Approval can only be deemed valid via agreement of the majority of Committee members (including a minimum of one Non-Executive Director and one Executive Director).

The Patient Finance and Cashiers Manager may in exceptional circumstances only approve disbursements of monies up to £500 from individual funds. In such instances, the Committee should be contacted in advance of such disbursement.

The Committee shall have the authority to seek external legal advice or other independent professional advice on request by the Chair.

The Committee can establish and approve terms of reference for such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

Reporting

A Chair's report following each meeting will be submitted to the Corporate Trustee. Where a significant risk emerges either through a report or through discussion at the meeting, this will be reported to the Corporate Trustee by the Committee Chair.

Links to other sub-committees/forums

Reports directly to the Corporate Trustee

Monthly-bid review sub-group meeting has been established during 2023-24

Review

Date of committee review: October 2023
Date of Board approval: November 2023
Date of previous Board approval January 2023

22. INTEGRATED CARE SYSTEM / INTEGRATED CARE BOARD UPDATE

James Duncan, Chief Executive

verbal update

22.1 NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE GOVERNANCE

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

22.1a Cover sheet collaborative update.pdf

22.1b Collaborative Update on Governance for FT Boards Oct 2023 (Shared).pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**North East and North Cumbria Provider Collaborative Governance**
Executive Lead	**James Duncan, Chief Executive**
Report author	**James Duncan, Chief Executive**

Purpose of the report	
To note	**x**
For assurance	
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	
2. Person-led care, when and where it is needed	
3. A great place to work	
4. Sustainable for the long term, innovating every day	x
5. Working with and for our communities	

Meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
Provider Collaborative/Lead Provider	
People	
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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 and experience		Service user, carer and stakeholder involvement	

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

Board of Directors

Wednesday 1st November 2023

North East and North Cumbria Provider Collaborative Governance

Executive Summary

In July 2022, the Collaborative provided an update to Trust Boards noting the agreement for the 11 Foundation Trusts in NENC to formally work together set out in the 'Collaboration Agreement'. All Trust Boards approved these by September 2022.

The purpose of this report is to update the Board on the governance arrangements for the NENC Provider Collaborative, specifically focusing on the responsibility agreement with the ICB and strategic partnership agreed with NECs.

Recommendation:

1. The Board are asked to note the Responsibility Agreement between the ICB and Collaborative.

2. Note the strategic partnership between the Collaborative and NECS.

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

October 2023

1. Purpose

1.1. The purpose of this note is to update Boards on the governance arrangements for the NENC Provider Collaborative (the Collaborative) specifically focusing on the responsibility agreement (RA) with the ICB and the strategic partnership agreed with NECs.

1.2. Trust Boards are asked to note progress in these areas.

2. Context

2.1. In July 2022 the Collaborative provided an update to Trust Boards noting the agreement for the 11 Foundation Trust's in NENC to formally work together set out in the 'Collaboration Agreement'. This agreement was supported by an aims and aspirations document as well as an operating model. All Trust Boards approved these by September 2022.

2.2. In presenting the formal collaborative approach it was noted that the final element of these arrangements was a responsibility agreement (RA) with the ICB which was under discussion at that point in time. That agreement is now in place for 2022/3, with the following summarising the requirements and the full RA attached at appendix A.

3. Responsibility Agreement

3.1. NHSE guidance on the functions and governance of the integrated care board (August 2021) stated that:

> *Provider collaboratives will agree specific objectives with one or more ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.*
>
> *The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.*

3.2. To meet this requirement the Collaborative and ICB have established a responsibility agreement (RA) which defines and describes the working relationship between the ICB and the Collaborative. It provides a framework for building an ongoing relationship recognising that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.

3.3. The RA also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments. It is an annual arrangement that will be reviewed and refreshed in year, with an agreement for 24/5 to be in place for 1st April 2024.

3.4. The RA recognises that the Collaborative's Provider Leadership Board will determine programme governance structures required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams. Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

3.5. The RA recognises that areas of work will evolve over time and there will be a need to respond to emerging and ad hoc requirements. However it does set out the specific work programmes agreed between the ICB and the Collaborative for 2023/4, which are summarised below:

i. Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.

ii. Delivery of a diagnostics plan and programme.

iii. Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.

iv. Continued implementation of the aseptic manufacturing hub.

v. Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital.

vi. Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements.

3.6. The RA established a Collaborative operational budget of £1.3m for 2023/4. This is comprised of:

- £600K contribution from the NECS (on behalf of ICB)
- £200K roll over of underspend from previous years
- £500K contribution from Trusts.

4. Strategic Partnership with NECS

4.1. As part of evolving working arrangements the Collaborative has agreed to form a strategic partnership with NECS. This recognises the role and support which NECS has offered in the establishment of the Collaborative and the ongoing alignment of priorities and work areas for the Collaborative and NECS focusing on, specifically:

- The deployment of resources and support across system programmes and areas, covering people, digital and analytical requirements;
- The identification of economies of scope and scale in corporate, clinical and clinical support services;
- The delivery of system priorities where there is appropriate congruence (e.g. elective recovery);
- The building of capacity and capability to ensure future resilience through the identification, development and deployment of digital tools and AI to the mutual benefit of the partners;
- Developing population-based approaches to the management of patients to facilitate better care, outcomes and utilisation of resources;
- Mutual development of skills, leadership and associated development for clinical and non-clinical staff.

4.2. This relationship will enable the Collaborative to draw upon the capabilities of NECS and its wider expertise and experience via its comprehensive supply chain as well as being able to shape the direction and development of NECS' strategic direction and priorities.

5. Recommendation

5.1. The FT Boards of the eleven NENC Provider Collaborative members are asked to:

i. Note the Responsibility Agreement between the ICB and Collaborative
ii. Note the strategic partnership between the Collaborative and NECS

Matt Brown
Managing Director
North East and North Cumbria Provider Collaborative
26th September 2023

Appendix A: Responsibility Agreement

Appendix A

North East and North Cumbria Provider Collaborative

North East and North Cumbria

PROVIDER COLLABORATIVE RESPONSIBILITY AGREEMENT

2023/24

1 PURPOSE

This Responsibility Agreement defines and describes the working relationship between the North East and North Cumbria (NENC) Integrated Care Board (ICB) and the NENC Foundation Trust Provider Collaborative (the Collaborative). It provides a framework for building an ongoing relationship and collaboration, which recognises that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.
- It also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments.

2 BACKGROUND

The Provider Collaborative provides a formal mechanism for collective decision making across all 11 FTs on important 'whole system' issues in NENC. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, through an approach that will be additive, tackle unwarranted variation and enhance working at Place.

The Collaborative began working together in 2019 with

arrangements formally endorsed by Trust Boards over the summer of 2022.

3 MEMBERSHIP OF THE PROVIDER COLLABORATIVE

The Members of the Collaborative are all of the foundation trusts (FTs) within NENC:

- County Durham and Darlington NHS FT
- Cumbria, Northumberland, Tyne and Wear NHS FT
- Gateshead Health NHS FT
- Newcastle Upon Tyne Hospitals NHS FT
- North Cumbria Integrated Care NHS FT
- North East Ambulance Service NHS FT
- North Tees and Hartlepool NHS FT
- Northumbria Healthcare NHS FT
- South Tees Hospitals NHS FT
- South Tyneside and Sunderland NHS FT
- Tees, Esk and Wear Valleys NHS FT

3 REMIT

3.1 General

The Collaborative will identify and deliver a programme of mutual benefit and that:

- Contributes to the delivery of the NENC Integrated Care Strategy, in particular its long term goal of 'Better Health and Care Services' by identifying opportunities to improve the quality and sustainability of the health services in the Region, towards a goal of all statutory organisations regulated by the Care Quality Commission being rated either 'Good' or 'Outstanding'.

- Supports the efficient and effective use of resources within its member organisations, with a focus on opportunities to collaborate and/or share resources and to identify and reduce unwarranted variation

- Undertakes collective strategic workforce planning in collaboration with national and regional teams

- Develops opportunities to act as 'anchor institutions', including supporting economic development by leveraging their power as large employers and purchasers.

- Supports the achievement of the integrated care strategy goals of 'longer, healthier life expectancy' 'fairer outcomes'.

3.2 Specific work programmes agreed between the ICB and the Collaborative for 2023/24

- Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.

- Delivery of a diagnostics plan and programme

- Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.

- Continued implementation of the aseptic manufacturing hub

- Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital

- Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements

3.3 As appropriate the Provider Collaborative and the ICB will identify in issues and opportunities where a collective provider response is required. This could include specific service issues (for example development and deployment of response to CMDU) to cross cutting issues (e.g. developing an approach to repatriations).

3.4 The ICB will support the Collaborative in its work which will include access to appropriate resourcing for system objectives as well access to appropriate data and analytics to inform work, where the ICB holds this information, on the principle of 'do it once'. The ICB will also ensure appropriate officer involvement in Collaborative work programmes as agreed with the Collaborative.

4 GOVERNANCE ARRANGEMENTS

It is recognised that these arrangements may evolve over time.

The Provider Collaborative operates as a formal partnership of all 11 NHS Foundation Trusts (FTs) in NENC. It is a whole system collaborative acting, at scale across multiple FTs with individual FTs continuing to work with each other in collaborative arrangements on a geographical or sectoral basis and play full roles within their relevant place-based partnerships, working closely with local communities and partner organisations.

It is underpinned by a formal collaboration agreement, operating under a provider leadership model, with formal mechanisms for collective decision making across all FTs on important 'whole system' issues. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, rather than being a separate formal entity. Individual organisations remain accountable in line with NHS governance and regulatory requirements.

The PLB will determine the programme governance structure required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams.

Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

5 RESOURCES

Based on the work programme contained within this agreement, the resources for 23/24 are set out below in summary, together with the funding sources. A programme staff organisation chart is provided as appendix 1

Costs banded at top of grade, or actual where available.

Post	WTE	Band	Annual cost £k	23/24 cost £k
Managing Director (hosted by NUTH)	1.0	VSM	130	130
Director of Elective Recovery & Transformation (NHSE)	0.4	VSM	60	60
Elective Programme Director (NECS)	1.0	8D	605	605
Corporate Programme Director (NECS)	1.0	8D		
Senior Development Lead (NECS)	1.0	8D		
Senior Project Manager (NECS)	1.0	8A		
Programme Support Officer (NECS)	1.0	5		
Mutual Aid Lead (STSFT)	0.4	8A	30	30
Project Support Officer (NECS)	1.0	5	60	60
Senior Programme Support Officer (Gateshead)	1.0	6	55	30
Subtotal (filled)			***940***	***915***
Vacant				
Clinical Programme Lead	1.0	8C	95	70
Project Manager	4.0	7	240	180
Performance & Intelligence Lead	0.6	8A	45	30
Finance Lead	0.2	8A	15	10
Comms Lead	1.0	6	60	45
Administrative Assistant	1.0	3	30	20
Clinical Leadership & Backfill			30	30
Subtotal (vacant)			***515***	***385***
Non pay (inc corporate support eg HR, finance)			30	30
Total Costs			**1,485**	**1,330**
Income				
Carry over from 22/23				180
NECS contribution				500
ICB contribution				100
FT contribution (£550k/11 = **c£50k per FT**)				550
Total Income				**1,330**

Note – the right-hand column, denoted 23/24 cost (£k), takes account of likely actual in-year costs, for example due to recruitment taking place mid-year

Separate funding streams are in place in 23/24 for:

- Aseptics Project Director

- Aseptics Project Manager
- Cancer Programme Manager
- Diagnostics Programme

There will be other potential posts through the Provider Collaborative, such the Digital Diagnostics Implementation Leads, pharmacy and procurement opportunities e.g., diabetic devices.

In addition, the ICB and will support the Collaborative in the following ways:

- A shared approach to the use of BI resources, including a commitment to 'do once and share'
- Support from the ICB Programme Management Office, and access to a suite of project management and quality improvement tools
- Support for the team, with a link executive and team (the Chief of Strategy and Operations)

6 AGREEMENT

Insert signature	Insert Signature
Ken Bremner Chair, Provider Collaborative Insert Date	Sam Allen CEO, Integrated Care Board Insert Date

22.2 ICS JOINT FORWARD PLAN - DRAFT

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

22.2 Board paper JFP Nov 2023.pdf

Report to the Board of Directors
Wednesday 1 November 2023

Title of report	**North East and North Cumbria System Joint Forward Plan 2023-24 to 2028-29**
Report author(s)	**Anna Foster, Trust Lead for Strategy and Sustainability**
Executive Lead (if different from above)	**James Duncan, Chief Executive**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	X
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	X
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	X
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	X
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	x

Board Sub-committee meetings where this item has been considered	
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	
Executive Team	x
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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	
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

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
Wednesday 1 November 2023

North East and North Cumbria Joint Forward Plan 2023-24 to 2028-29

Background

1. The North East and North Cumbria Integrated Care Board (ICB) and their partner NHS Trusts (including CNTW) have developed a five year joint forward plan (JFP), a statutory requirement. While the formal responsibility for developing the plan was with the ICB and partner NHS Trusts, the plan serves as a shared vehicle to deliver the North East and North Cumbria integrated care strategy, joint local health and wellbeing strategies and to complement provider trust strategies. It is hoped that the joint forward plan will be supported by the wider health and social care system, including local authorities and voluntary, community and social enterprise (VCSE) sector partners.

Overview

2. The region-wide, system plan describes how the ICB and partner NHS Trusts intend to 1) arrange and/or provide NHS services to meet our population's physical and mental health needs and 2) deliver the NHS long term plan / universal NHS commitments.

3. The joint forward plan provides a summary of the detailed action plans developed by clinical networks, integrated care system workstreams and place-based arrangements. These plans have been developed through partnership-based engagement, and delivery of the plan will be overseen by the ICB Executive Committee. The ICB Mental Health, Learning Disabilities and Autism Sub-Committee has an important delivery role. The JFP will be refreshed annually, commencing March 2024.

4. CNTW and our neighbouring trust, Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust collaboratively provided feedback to a draft version of the plan, demonstrating the commitment of both trusts to partnership working and to influencing the system. The final version of the plan has clearly incorporated our feedback, which highlighted areas we felt would benefit from strengthening, particularly, a) community mental health transformation b) learning disability, autism and neurodevelopmental conditions and c) Children and Young Peoples' mental health.

5. The JFP complements the NENC ICS Integrated Care Strategy ‘Better Health and Wellbeing for All’ (published December 2022) and serves as a delivery plan for the NHS-related goals and enablers included in the strategy. The JFP also aligns with:
    - the CNTW strategy, ‘With you in mind’ (published May 2023);
    - the NHS National Operating Plan ambitions 2023/24;
    - the NHS Long-Term Plan;
    - local authority Health and Wellbeing Plans and Joint Strategic Needs Assessments.

Summary of the Plan

6. The joint forward plan reflects the ambitions in the ICS strategy. The summary below focuses on topics of particular relevance to CNTW:

Longer, Healthier Lives and Fairer Outcomes

7. This section of the plan commits to population health management, improving health literacy and tackling health inequalities via the CORE20PLUS5 framework, including annual health checks for adults living with serious mental illness, increased access to epilepsy care for people with a learning disability and autistic people and improved access to mental health services for certain ethnic groups.

Best Start in Life

8. This section of the plan prioritises the mental health of children and young people, with a commitment to partnership action across the system, improving access to services, including support teams in schools and early intervention services.

Better Health and Care Services

9. This section of the plan includes relevant commitments spanning personalised care, urgent and emergency care, mental health, neurodevelopmental services, learning disability and trauma-informed services. There are acknowledged gaps relating to dementia care and gender dysphoria services. Key points to note include commitments to:

    - 24/7 urgent mental health helplines accessible via 111;
    - Improved autism and other neurodevelopmental pathway and outcomes; including increased capacity to meet current and forecast demand for autism and attention deficit and hyperactivity disorder (ADHD) services;
    - reduced reliance on inpatient care and instances of long term segregation and seclusion for people with a learning disability;
    - community mental health transformation and improving access to services for people with severe mental illness and common mental health problems;
    - preventing suicide;
    - developing a safe, therapeutic, rights-based approach to inpatient care underpinned by the NHS England commissioning guidance published in July 2023
    - establish a plan to develop trauma-informed NHS services.

Enablers

10. The JFP also includes commitments to workforce development, supply, retention, health and wellbeing across the system, alongside a focus on leadership, on equality, diversity and inclusion (EDI) and on financial sustainability. There are also commitments to involvement and co-production, to innovation and technological advances and to place-based partnership working.

Recommendations

11. It is recommended that the Board endorse CNTW's role in delivering the North East and North Cumbria Joint Forward Plan 2023/24 to 2028/29 alongside system partners.

Anna Foster
Trust Lead for Strategy and Sustainability
October 2023

23. FINANCE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

23. 2324 - Board - Mth 6 Finance Board - Open (002).pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Name of meeting	**Board of Directors Meeting**
Date of Meeting	**Wednesday 1st November 2023**
Title of report	**Month 6 Finance Report**
Executive Lead	**Kevin Scollay, Executive Director of Finance**
Report author	**Kevin Scollay, Executive Director of Finance**

Purpose of the report	
To note	**x**
For assurance	
For discussion	
For decision	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day	
2. Person-led care, when and where it is needed	
3. A great place to work	
4. Sustainable for the long term, innovating every day	x
5. Working with and for our communities	

Meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	X
Charitable Funds Committee	
Provider Collaborative/Lead Provider	
People	
Provider Collaborative	
CEDAR Programme Board	
Other/external (please specify)	

Management meetings where this item has been considered	
Executive Team	x
Business Delivery Group	x
Trust Safety Group	
Locality Operational Management Group	
Executive Management Group	x

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
1687 – Managing resources effectively, 1762 – Restrictions in capital expenditure

Month 6 Finance Report

1. Executive Summary

1.1 A **The Trust has generated a £5.5m deficit year to date**. This includes a benefit from the land sale at Northgate of £5.8m, which has improved the year-to-date position significantly this month (£10.9m deficit last month). This benefit is non recurrent i.e. it cannot be repeated next year.

1.2 This deficit is **£0.2m better than the financial plan submitted to NHSE at Month 6**. This plan is phased to deliver deficits in the first 6 months of the year and surpluses for the second half of the year. Monthly financial targets became more challenging in Month 4. The Trust expects to deliver the increasingly challenging targets through a combination of expenditure reduction and non recurrent benefits.

1.3 **Monthly agency costs are higher than the agency ceiling, but are now lower than planned levels**. At the end of Month 6 the Trust has spent £9m (cumulative) on agency staff against a plan £8.4m and the Trusts nationally applied agency ceiling of £7.2m. The Trust is currently forecasting to reduce agency expenditure to below the agency cap levels in Quarter 4 this year.

1.4 **Expenditure on the Trust capital programme is £1.7m lower than planned** at Month 6. The Trust is forecasting to deliver against plan for the year and has revised the detail of the capital programme to ensure CDEL (capital budgets) are appropriately used before year end.

1.5 **The Trust has a cash balance of £34.2m** at the end of Month 6 which remains ahead of plan, but has reduced from last month.

2. Key Financial Targets

2.1 Table 1 highlights the key financial metrics for Month 6.

Table 1

	Month 6		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit)	(£5.7m)	(£5.5m)	(£0.2m)
Agency Spend	£8.4m	£9.0m	£0.6m
Cash	£20.7m	£34.2m	(£13.5m)
Capital Spend	£5.0m	£3.3m	£1.7m

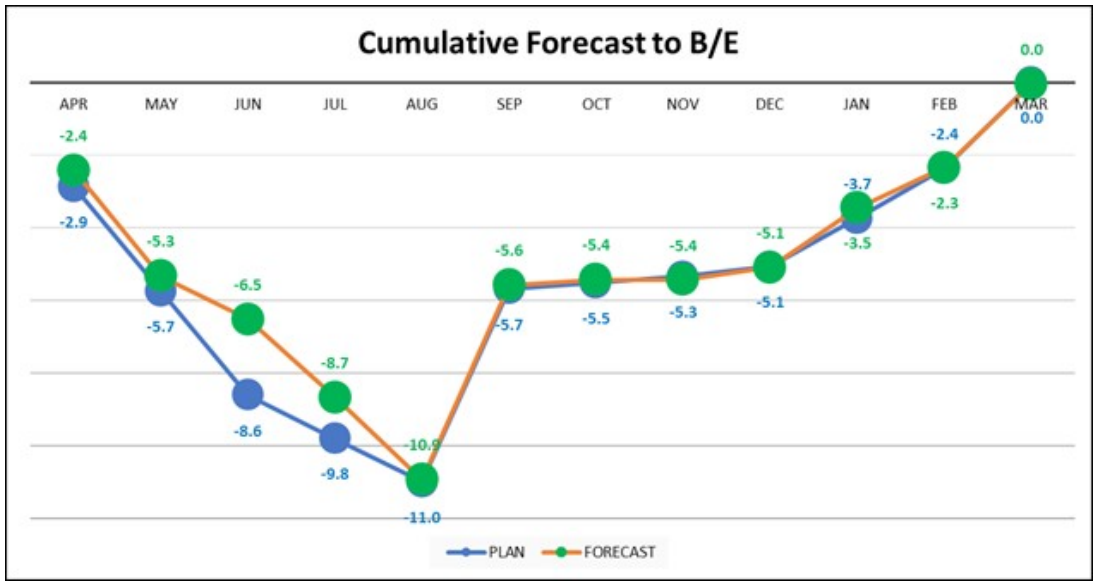
3. Financial Performance

Income and Expenditure

3.1 At the end of Month 6 the Trust has reported a £5.5m deficit on Income and Expenditure, which is ahead of the plan submitted to NHSE by £0.2m. This is a significant improvement on the year-to-date position reported last month as sale of land at the Northgate Site has been recognised in the position. The Trust continues to forecast a breakeven position. Savings plans (£28.1m) are heavily phased into Quarters 3 and 4 which are expected to be delivered through a combination of recurrent and non-recurrent measures. Some of these measures are also non-cash releasing in nature and consequently cash levels are expected to fall even based on delivery of the plan.

3.2 Graph 1 below shows the profile of the position reported to date (incl. land sale) along with the forecast position. The forecast is anticipated to track closely to the financial plan submitted at the start of the financial year. Given the emphasis on the financial position, supplementary sessions will be held with the Chairs of RABAC and Audit committee to ensure a sufficiently detailed understanding of this position is shared across key board members between quarterly meetings of these committees.

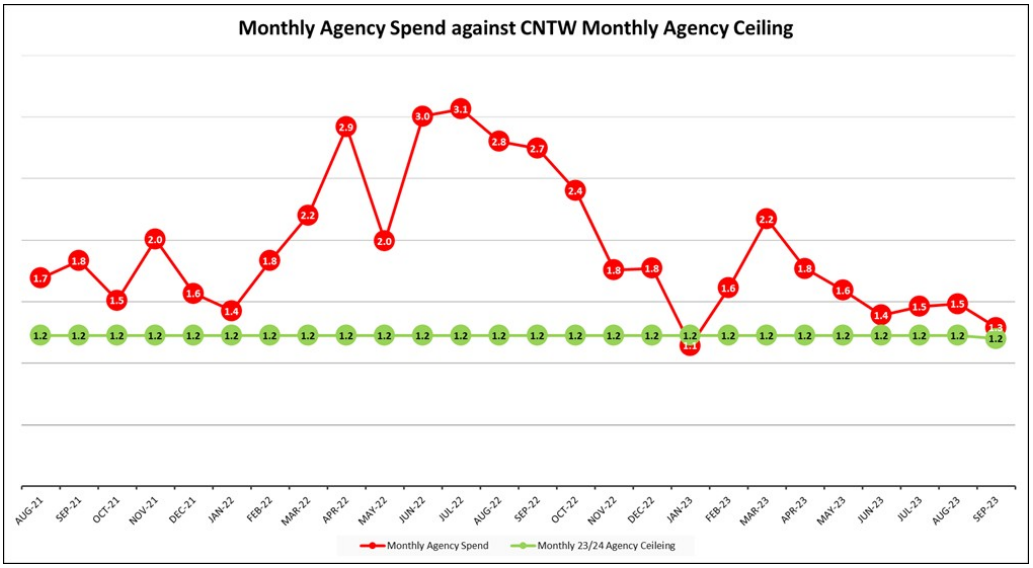
Graph 1



3.3 The Trust has a more ambitiously phased internal plan for CIP delivery and is currently managing to this trajectory internally.

3.4 Graph 2 below highlights the agency performance from August 2021. Costs in August stand at c£1.3m, with monthly costs reducing when compared with August. Costs remain above the Trust budget year to date, but is below the monthly budgeted level of £1.3m. Agency costs are higher than the 3.7% agency cap of c£1.2m per month as well as the prior year ambition to reduce to £1m per month, but are forecast to fall below the agency ceiling through Quarter 4.

Graph 2



3.5 Agency costs have been a focus for the Trust in managing it's overall financial position for a number of reasons. These inlcude;

- Quality implications of having high numbers of temporary staffing working within our services.
- The premium attached to agency staffing, which increases costs when compared with permanent staffing.
- The temporary nature of agency staffing is 'cost agile' which means it can be reduced quickly without secondary cost implications or lengthy management processes to reduce headcount.

3.6 It is worth noting, however, that the largest driver of overall Trust costs is the total usage of staffing resource – swapping temporary staffing for permanent stafing has a marginal impact on cost, but changing WTE numbers has a much larger impact.

3.7 This can be expressed in cost, but also in overall WTEs. The Trust is showing good progress in swapping agency staffing for substantive and bank staff. Agency remains down prior 24 month position with substantive staffing continuing to show growth. Increasing substantive staffing and reducing agency should improve cost effectiveness and support improving quality in the organisation. However, WTEs continue to rise, the net impact of which increases overall financial pressure on the organisation.

Table 2

	WTE Sept 22	WTE Aug 24	WTE Sept 24	Change Since Last month	Change in 24 Mth
Substantive	7,205	8,146	8,166	19.68	961.42
Bank	332	286	307	20.27	(25.78)
Agency	369	295	305	9.52	(64.40)
	7,906	**8,728**	**8,777**	**49.47**	**871.24**

4. Cash

Table 3

	Year To Date		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**
Cash	20.7	34.2	(13.5)

4.1 Cash balances at the end of September were £13.5m higher than plan, but have reduced in Month 6.

4.2 The Trust received £15m in PDC funding to support the CEDAR programme in 2023/24, which was not included in the Trust financial planning for 2023/24.

4.3 Underspending on the capital plan year to date is also supporting better than expected cash balances.

4.4 The 2023/24 financial plan includes non-cash transactions to support delivering financial break-even, this means that cash levels are expected to fall over the year, depsite forecasting a breakeven position.

5. Capital & Asset Sales

Table 4

	Year To Date			Year End		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**	**Plan (£m)**	**Forecast (£m)**	**Variance/ Rating (£m)**
Capital Spend	5.0	3.3	(1.7)	20.8	18.9	(1.9)
Asset Sales	0.0	0.0	(0.0)	6.8	7.0	0.2

5.1 The Trust Capital spend at the end of Month 6 is £3.3m is £4.5m which is £1.7m less than the plan. The Trust is currently forecasting an underspend against the capital budget included in the original plan, however, this plan included a CDEL expectation associated with the CEDAR business case addendum. The CDEL and cost expectation has been revised downwards for 23/24 and upwards for 24/25. The trust therefore expects to fully utilise CDEL resources allocated to it, but as plan submitted to NHSE at the start of the year cannot be changed, this presents as an underspend against the capital plan.

6. Recommendations

6.1 The Board is asked to note the content of this report.

24. QUALITY AND PERFORMANCE COMMITTEE

Darren Best, Chair

verbal update

25. AUDIT COMMITTEE

David Arthur, Chair

Verbal update

26. RESOURCE AND BUSINESS ASSURANCE COMMITTEE

Paula Breen, Chair

verbal update

27. MENTAL HEALTH LEGISLATION COMMITTEE

Michael Robinson, Chair

verbal update

28. PROVIDER COLLABORATIVE COMMITTEE

Michael Robinson, Chair

No meeting held during the period

29. PEOPLE COMMITTEE

Brendan Hill, Chair

verbal update

30. CHARITABLE FUNDS COMMITTEE

Louise Nelson, Chair

verbal update

31. COUNCIL OF GOVERNORS' ISSUES

Darren Best, Chairman

32. QUESTIONS FROM THE PUBLIC

Darren Best, Chairman

33. ANY OTHER BUSINESS

Darren Best, Chairman

34. DATE AND TIME OF NEXT MEETING

Wednesday 6th December 2023
1:30 - 3:30pm
Trust Board Room, St Nicholas Hospital and Microsoft Teams