Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

6 December 2023

13:30 GMT Europe/London

Trust Board Room and via Teams

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1. AGENDA

Darren Best, Chairman

REFERENCES

Only PDFs are attached

BoD Agenda Draft Public 6.12.23 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 6 December 2023 Time: 1:30pm– 3:30pm

	Item	Lead	
1.1	Welcome and Apologies for Absence	Darren Best, Chair	Verbal
2	Service User / Carer / Staff Journey	Guest Speaker	Verbal
3	Declarations of Interest	Darren Best, Chair	Verbal
4	Minutes of the meeting held 1 November 2023	Darren Best, Chair	Enc
5	Action Log and Matters Arising from previous meeting	Darren Best, Chair	Enc
6	Chairman's Update	Darren Best, Chair	Verbal
7	Chief Executive Report	James Duncan, Chief Executive	Enc
Quality, Safety and patient issues			
8	Integrated Performance Report (Month 7)	Ramona Duguid, Chief Operating Officer	Enc
9	Service User and Carer Experience Q2 Report	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc
Workforce issues			
10	None to note for the period		
Regulatory / compliance issues			

11	**Health Inequalities Framework**	**Lynne Shaw, Executive Director of Workforce and OD**	**Enc**
12	**Annual Deanery Report**	**Rajesh Nadkarni, Deputy Chief Executive and Medical Director**	**Enc**
13	**Sub-Committees Terms of Reference**	**Debbie Henderson, Director of Communications and Corporate Affairs**	**Enc**
Strategy, planning and partnerships			
14	**Integrated Care System (ICS) – system update**	**James Duncan, Chief Executive**	**verbal**
15	**Finance Report**	**Kevin Scollay, Executive Director of Finance**	**Enc**
Committee updates			
16	**Quality and Performance Committee** **Audit Committee** **Resource and Business Assurance Committee** **Mental Health Legislation Committee** **Provider Collaborative Committee** **People Committee** **Charitable Funds Committee** *No meetings held during the period*	**Committee Chairs**	**N/A**
17	**Council of Governors' Issues**	**Darren Best, Chair**	**Verbal**
18	**Questions from Governors and the Public**	**Darren Best, Chair**	**Verbal**
19	**Any other business**	**Darren Best, Chair**	**Verbal**
Date and Time of Next Meeting: **Wednesday 7 February 2024** **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 JOURNEY

Guest Speaker

3. DECLARATION OF INTEREST

Darren Best, Chairman

4. MINUTES OF THE MEETING HELD 1 NOVEMBER 2023

Darren Best, Chairman

REFERENCES

Only PDFs are attached

4. Public Minutes 1 November 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
Paula Breen, 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
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance
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
Kirsty Allan, Corporate Governance Manager / Deputy Trust Secretary (minutes)
Jack Wilson, Corporate Engagement Assistant
Tom Rebair, Deputy Lead Governor / Adult Service User (online)
Jane Noble, Carer Governor, Adult Services
Fiona Regan, Autism Services Governor
Jessica Juchau-Scott, Carer Governor, Older People's Services
Jodine Milne Reader, Public Governor, Sunderland
Elaine Lynch, Local Authority Governor, Cumberland Council
Margaret Adams, Chair of the Service User and Carer Reference Group
Chris Rowlands, Equality, Diversity and Inclusion Lead

1. Welcome and apologies for absence

Darren Best welcomed everyone to the meeting. There were no apologies for absence received.

2. Declarations of interest

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

3. Service User/Carer Story/ Staff Journey

Darren Best extended a warm welcome and thanks to Jane Noble who shared her personal journey through Inpatient, Community, Psychiatric Liaison and Crisis Team services. Jane also shared her thoughts on transformation and working more collaboratively with services.

4. Minutes of the meeting held 4th October 2023

The minutes of the meeting held on 4th October 2023 were considered and agreed.

Approved: • **The minutes of the meetings held 4th October 2023 were approved.**

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

02.08.2023 (8) Integrated Performance Report – Ramona Duguid advised an update will be provided within the Month 6 Integrated Performance Report regarding psychiatric liaison referrals. A detailed summary was presented to and discussed at the Quality and Performance Committee. It was agreed to close the action.

05.07.2023 (7) CE Report: Institute for Public Policy Research Health and Care Workforce Assembly report – James Duncan suggested meeting with Brendan Hill to work through further information to be brought back to a future meeting.

06.09.2023 (8) Integrated Performance Report – Sarah Rushbrooke advised that a detailed update on the impact of the Right Care Right Person model will be shared with a future Quality and Performance Committee.

04.10.2023 (8) – Integrated Performance Report – Lynne Shaw confirmed that the training needs analysis will be submitted to the January meeting of the People Committee with an update in December's Integrated Performance Report.

6. Chairman's update

Following a recommendation from Darren Best, the Board supported the appointment of Brendan Hill as Vice Chair. Confirmation of this appointment will be provided to the November Council of Governor's meeting.

Darren provided an update on the recruitment process for the two Non-Executive Director posts noting that following receipt of 56 expressions of interest, 9 were shortlisted. Shortlisting resulted in a balanced mix of candidates from a culturally diverse background.

Darren noted that a Board development session will take place on 22 November to discuss the approach to Board and Board Committee meetings. Darren also advised that this work would provide the context of a wider review of governance and meeting arrangements for the Council of Governors to ensure appropriate alignment between the Board of Directors and Council of Governors to ensure both groups were operating to maximum effectiveness.

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

7. Chief Executive's Report

James Duncan highlighted the 'treating tobacco dependency in mental health conference' being a powerful event which aims to support the shift required in 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.

The Triangle of Care Annual Report was found to be clear and honest, highlighting engagement and involvement at all levels of the Trust. The provides includes feedback as well as clear actions for the future. The Trust has successfully retained a 2-star accreditation status.

The North East and North Cumbria Health and Care Partnerships ran a summit on 25 October 2023 which explored the current support available for children and young people across North East and North Cumbria and opportunities for improvement. James reflected on the summit mentioning supporting children and young people to have the right start in life, the need to have wrap-around support for families who are struggling and the need to intervene as early as possible. James explained the summit provided an opportunity for the Trust to reflect on its approach to the CNTW Children and Young People's programme of work.

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

Quality, Clinical and Patient Issues

8. Monthly Integrated Performance Report (Month 6)

Ramona Duguid referred to the report and noted several positive areas of improvement in Month 6 including Psychiatric Liaison referrals in eating disorders and measures around CPA assessments

where there have been some challenges around data quality recording over previous months. There has been ongoing work shared with the Board on the focus on reducing restrictive practice and positive improvement around long-term segregation and seclusion. Ramona also noted the Trust has a position of zero out of area placements from 16th October to date which is testament to the ongoing focus on inpatient flow.

In terms of areas of mitigation and actions with recovery plans in place, an exception report was submitted to the Quality and Performance Committee following a deep dive into psychiatric liaison performance across all four localities.

The detailed monthly report on waiting times continues to be reported to the Quality and Performance Committee. Also included was the work on the Children and Young People's services neurodevelopmental pathway and the need for further actions in collaboration with the NENC ICB following the improvement workshops held in October.

There are several pieces of work being undertaken across localities to recognise the differences across the footprint in terms of pressures and demand linked to urgent care. A working group is in place to review the effectiveness of the implementation of the new standards for crisis services, including improving processes and recording.

Lynne Shaw noted an increase in sickness absence in August due to a rise in covid cases with provisional sickness rates for September reported as 6.21% remaining above the 5% standard. It has been agreed at the People Committee to undertake a deep dive on absence at the January meeting. There is a slight decrease in performance relating to staff appraisals which will be discussed at BDG workforce. There will be an in-depth review of training needs analysis which will include prioritising areas of training. This will be included in the Month 7 report.

Sarah Rushbrooke referred to the commitments to carers and patients' and highlighted a decrease in reported performance, due to the standard being increased this month to try and achieve even stronger service user and carer response rate. The Trust is currently undertaking a review of the Points of View experience survey.

Darren Best mentioned the individual committees review these areas in detail and suggested the report highlights links between performance metrics and the ambitions relating to the model of care review, particularly relating to the people metrics and organisational development.

James Duncan congratulated the teams regarding the reduction in out of area placements. The Inpatient Programme work has been fundamental in this achievement and firmly links to the Trust's strategic ambitions and commitments to service users and carers.

Resolved:
- **The Board received the monthly Integrated Performance Report (Month 6).**

9. Annual Safety, Security and Resilience Report 2022/23 (including EPRR Report Core Standards Assessment

Ramona Duguid referred to the report which has been discussed in detail at the Quality and Performance Committee. The report provides detail of the work that has been undertaken around emergency preparedness.

Darren Best noted the absence of reference to Cyber Security within the report. Ramona Duguid advised that Cyber Security work is reported separately through the Information Governance team.

Resolved:
- **The Board received and noted the Annual Safety, Security and Resilience Report 2022/23 (including EPRR Report Core Standards Assessment**

10. Safer Care Report

Rajesh Nadkarni referred to the report which focusses on key metrics to enable improved data analysis and identification of areas that require further investigation or review. The narrative provided an analysis of the data while the key points section provided additional areas of note and assurance.

The Information Governance team continue to see a higher-than-average number of incidents reported during the period. Key themes are noted in the report and in the coming months, Information Governance team will be running a campaign to raise awareness of the importance of Information Governance.

Serious incidents are in-line with common variation which are submitted for review through Trust wide Safety Group with a process of managing and reviewing incidents. There have been no Regulation 28 reports within the quarter and restrictive practice data shows a trend reduction of Mechanical Restraint Equipment (MRE) use and seclusion incidents.

Rajesh mentioned the Trust is seeing a high level of safeguarding activity. This is reflective of national increases and greater awareness due to the rollout of Level 3 training. The Safeguarding and Public Protection team continue to have oversight of all reported safeguarding incidents and continue to provide support, advice and supervision where required across all localities.

Resolved:
- **The Board received and noted the Safer Care Report**

11. CQC Must Do Report update

Sarah Rushbrooke referred to the report which was considered in detail at the Quality and Performance Committee and 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 the new Sycamore Unit at Northgate Park.

Sarah advised of extensions to the completion dates of some action plans relating to the training needs analysis work.

Sarah advised that discussions were taking place with Louise Nelson as Chair of the Quality and Performance Committee to further develop the report and mechanisms for reporting relating to Must Dos from an assurance perspective.

Oversight continues of the 14 open action plans that remain and 40 have closed out of the 57 original Must Dos.

Darren Best explained that as Quality and Performance have agreed to close action plans this report would therefore be for information only to the Board.

Resolved
- **The Board received the CQC Must Do report and approved to close three actions plans**
- **Future reports to be for information only once the report has been sighted and approved at Quality and Performance Committee**

12. Quality Priorities update (Quarter 2) report

Ramona Duguid confirmed the Trust continues to comply every year with the NHS England requirements to produce the Quality Account setting out the quality priorities for the Trust for the year ahead. Ramona confirmed the report was reviewed at Quality and Performance Committee.

Resolved
- **The Board received and noted the Qualities Priorities update (Quarter 2) report**

13. Patient Safety Incident Response Framework Plan and Policy

Rajesh Nadkarni referred to the report which was discussed at the Quality and Performance Committee. The policy and plan require Board approval prior to submission to the NENC ICB.

Rajesh explained being a very important juncture in the Trust approach to learning. The policy describes the organisations approach to reporting of patient safety incidents for the purpose of learning and improvement and the plan outlines the Trust patient safety incident profile and details the methods used to respond in a way that maximises learning and improvement. Both documents have been developed using outputs from several workshops and workstreams, including service user and carer involvement, covering different aspects of patient safety incident response.

David Arthur emphasised the need to have sight of learning from other organisations to enable the Trust to take learning externally as well as internally.

Approved

- **The Board approved the Patient Safety Incident Response Framework Plan and Policy**

Workforce updates

14. Equality, Diversity and Inclusion Improvement Plan

Chris Rowlands referred to NHS England's EDI Improvement Plan published June 2023. The Trust undertook a mapping exercise against the six high impact actions and the report provides assurance of evidence against the actions. Work is still required in relation to action 2 and 6 in relation to developing wider programmes of work that span all protected characteristics, improving progression opportunities for staff from protected characteristics and eliminating the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Chris referred to the recent release of the Patient Carer Race Equality Framework (PCREF) which focusses on leadership and governance, organisational competence and patient and carer feedback mechanisms. Chris suggested that engagement is key to successful implementation and Trusts are to agree co-produced priorities with local communities, supported by measurable actions that are routinely monitored. There are three high level priorities for 2023 -2025 which are outlined in the report.

Progress against the EDI improvement plan and PCREF will be monitored by the People Committee. Brendan Hill, as Chair of People Committee, provided assurance that work continues to embed the plan and framework within the wider workforce priorities for the Trust.

Darren Best set out the requirement for Board members to have an objective in relation to EDI as part of their appraisal process to support this work and invited Chris to develop some objectives for the Board to consider.

Resolved

- **The Board received and noted the Equality, Diversity and Inclusion Improvement Plan**

Action

- **Chris Rowlands to develop some objectives for individual Board members relating to their commitment to EDI for inclusion in appraisal processes**

15. Guardian of Safe Working Report

Rajesh Nadkarni noted that there have been 24 exception reports submitted during the period. This represents an increase from the previous quarter and when compared to the same period in 2022/23.

50% of the exception reports have been submitted by higher trainees, but Rajesh advised that there were no specific rotas or areas of concern. Rajesh suggested that the increase may represents an increase in more complete reporting which is encouraging.

Resolved
- **The Board received and noted the Guardian of Safe Working report**

16. 1 Raising Concerns – Whistleblowing Report

Lynne Shaw referred to the six-monthly report which highlights 46 cases that have been raised via the Freedom to Speak Up Guardians or centrally which is an increase from the previous six months. The report includes themes of concerns raised and now differentiates between bullying and harassment and those linked to bullying and harassment experiences by those with protected characteristics.

Resolved:
- **The Board received and noted the Raising Concerns – Whistleblowing Report**

16.2 Freedom to Speak Up Reflection Took and Action Plan

Lynne Shaw referred to two documents produced by the National Guardians Office two years ago, the national speaking up policy which has now been implemented in its entirety within the Trust and the reflection planning 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 Brendan Hill, 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.

Lynne mentioned high level actions that are required to bring about improvement which are to review processes for identifying and addressing detriment, consider how learning can be shared of positive speaking up stories and a review of the communication strategy with the Freedom to Speak Up Guardians.

Resolved
- **The Board received and noted the Freedom to Speak Up Reflection Tool and Action Plan**

17. International Recruitment update

Sarah Rushbrooke referred to the report which outlines plans for an imminent pause on international nurse recruitment. There has been a very successful programme for recruitment of international nurses which has been heavily relied upon to deliver high quality, safe services. Due to the number of key operational and professional issues over recent months a decision has been made to pause recruitment 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 internationally educated professionals.

The Board noted and supported the pause on international recruitment of educated nurses which will enable a review of the related processes and development of a plan to enhance leadership opportunities for international nurses to complement locality workforce plans.

Darren Best suggested if the pause is to go beyond the end of the financial year to provide a further update to Board.

Resolved: • **The Board received and noted the International Recruitment update**

Regulatory / Compliance updates

18. NHSE/I Single Oversight Framework Compliance Report

Ramona Duguid referred to the report for information and noted the Trust is now in a programme of providing assurance to the NENC ICB through Provider Oversight meetings.

Resolved: • **The Board received and noted the NHSE Single Oversight Framework Compliance report**

19. Infection Prevention and Control (IPC) Board Assurance Framework

Sarah Rushbrooke referred to the report and highlighted a slight increase in the number of COVID cases during recent months. Sarah confirmed that the 2023/24 winter Flu COVID-19 vaccination campaign launched on 9th October.

Resolved: • **The Board received and noted the Infection Prevention and Control (IPC) Board Assurance Framework**

20. Board Assurance Framework (BAF) 2023

Debbie Henderson confirmed the new Board Assurance Framework and high-level strategic risks had been reviewed by all Board Committees. The new BAF and risk appetite had been developed by the Board following detailed discussion at the Board Development session held 20th September. This included a review of the purpose of the BAF in the context of current challenges and enabling the Board and Committees to be more focused on areas of concern.

Debbie advised that the new BAF now includes risks associated with the importance of ensuring a positive safety learning culture, and risks relating to digital. Debbie highlighted a current gap within the Trust's governance structure relating to the separation of digital risks, both in terms of cyberthreat and digital solutions reporting to the Resource and Business Assurance Committee and data protection / information governance reporting to Quality and Performance Committee. Kevin Scollay as Executive lead will discuss this further to ensure alignment in this regard.

Debbie referred to the new Risk Appetite statement which has been developed and endorsed by the Board at the meeting on 20th September. There are 11 categories identified within section 5 of the report, which reflect the inclusion of digital risks, workforce risks, model of care risks and innovation. The appetite for financial risk has been reevaluated from 'moderate' to 'low', and appetite for climate risk has been re-evaluated from low to moderate.

The Board agreed the new Board Assurance Framework and Risk Appetite which will be included in the new risk management policy following a consultation in December which will then be further submitted to the January Board for approval and implementation.

Resolved • **The Board received and approved the New Board Assurance Framework**

21. Board Committee Annual Review against Terms of Reference 2023

Debbie Henderson referred to the report which provided an overview of the review, and where appropriate amendments to the Terms of Reference for the Board and Board Committees. The Board

Committees reviewed their relevant Terms of Reference and annual review at their respective meetings.

A key theme highlighted at all Committees related to the need to strengthen induction arrangements for new Committee members including Governors.

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 report.

Ramona Duguid noted that locality level representation was incorrect and it was agreed that this be clarified following the meeting.

Approved:

- **The Board approved the Board Committee Annual review and Terms of Reference for Board Committees, subject to clarification of locality membership.**

Strategy, planning and partnerships updates

22. Integrated Care System (ICS) / Integrated Care Board (ICB) update

James Duncan advised the North East and North Cumbria Provider Collaborative 'collaboration agreement' was agreed by all 11 providers in September 2022. The paper provides an overview of the governance arrangements for the NENC Provider Collaborative, specifically focusing on the responsibility agreement with the NENC ICB and strategic partnership agreed with NECs.

Resolved:

- **The Board received and noted the Integrated Care System / Integrated Care Board update and Provider Collaborative governance update.**

23. Finance Report

Kevin Scollay advised the Trust has generated a £5.5m deficit year to date which includes a benefit from the land sale at Northgate. This has improved the year-to-date position but was acknowledged as a non-recurrent benefit. 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.

Resolved

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

Board sub-committee minutes and Governor issues for information

24. Quality and Performance Committee

Louise Nelson advised that many issues were discussed as part of the substantive meeting and there were no other significant issues to report.

25. Audit Committee

David Arthur provided an update following the October meeting which discussed the plan for the external auditor appointment process. The Trust's current auditors, Mazars presented their audit plan for NTW Solutions with an extraordinary meeting of the Committee taking place in December to sign off NTW Solutions annual accounts. The Committee also received an update on the issue of staff alarms and the rostering system following limited assurance reports from Internal Audit.

26. Resource and Business Assurance Committee

Paula Breen provided an update following the October meeting it was agreed that the digital portfolio report to the Committee from a governance and assurance perspective.

27. Mental Health Legislation Committee

Michael Robinson provided an update following the October meeting noting the cancellation of a number of recent meetings of the Mental Health Legislation Steering group therefore a number of actions from previous meetings remain outstanding.

Michael referred to a development session for both Board members and Governors on the legal and statutory obligations and duties of CNTW underpinned by mental health legislation at the meeting scheduled to take place on 8 December.

28. Provider Collaborative Committee

No meeting was held during the period.

29. People Committee

Brendan Hill provided an update following the October meeting noting the challenges which remain relating to training metrics. There were improvements noted relating to the standard for clinical supervision with increased focus centred around this as a CQC must do. A discussion took place regarding prioritisation of training via a training needs analysis.

30. Charitable Funds Committee

Louise Nelson provided an update following the October meeting noting that the Charity received a detailed update on the Charity Strategy and delivery plan. It was noted that a significant amount of activity has been undertaken over the last 6 months including income generation including the successful bid of £156k to NHS Charities Together to support 8 separate initiatives across the Trust. The Committee is also in the process of reviewing investment companies to align to the values and commitments of the Trust and its charity.

31. Council of Governors issues

Darren Best provided an update on the current Governor Elections with results to be confirmed on 30th November with 11 current vacancies within the Council.

Darren referred to a good discussion at a Governor Engagement meeting on 12th October where Governors received an update on strategy and planning.

32. Any Other Business

No other business to note.

33. Questions from the public

There were no questions from the public.

Date and time of next meeting

Wednesday, 6 December 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 6 Dec 2023.pdf

Board of Directors Meeting held in public

Action Log as at 6 December 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			
05.07.23 (7)	CE Report	Discussion on the Institute for Public Policy Research Health and Care Workforce Assembly report to be undertaken at a future Board meeting	James Duncan / Brendan Hill	January 2024	Clarification on expected completion date to be provided at a future Board meeting
04.10.23 (8)	Integrated Performance Report	Briefing to be provided to the People Committee on the Training Needs Analysis review and summary of training requirements for all designations of staff	Lynne Shaw	January 2024	Clarification on expected completion date to be provided within December Integrated Performance Report
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	January 2024	Will be shared with a future Q&P Committee
		Completed Actions			
02.08.23 (8)	Integrated Performance Report	A focussed discussion on Psychiatric Liaison Referrals to be undertaken	Ramona Duguid/ Rajesh Nadkarni	November 2023	Completed – on November agenda

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 December 2023.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6th December 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		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	
Quality, safety and experience		Service user, carer and stakeholder involvement	

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

With YOU in mind

Trust updates

Duchess of Northumberland opens new Sycamore unit at Northgate Park hospital

Her Grace Jane Percy, The Duchess of Northumberland, has officially opened the new Sycamore unit at CNTW's Northgate Park hospital. Sycamore is a new, state-of-the-art secure facility which looks after men with a mental illness, learning disability or personality disorder who have come into contact with the criminal justice system. It contains 72 beds across six wards. The trust began redeveloping the Northgate hospital site in 2020, as the existing buildings – some of which dated back to the 1960s – were no longer fit for purpose and were unable to be adapted. To raise the standard of care and meet the demand for secure services, new buildings were needed. Work began on the unit in November 2020, and the successful opening of the unit is the result of the hard work and dedication of many hundreds of staff.

The unit has been carefully designed to the highest standards, equipped with cutting-edge technology and a variety of spaces to ensure that patients receive the best possible care. These purpose-built spaces include an education suite, art rooms, sport and exercise facilities, a workshop for woodwork, and gardens. The new building also features imagery of local wildlife, plants, and landscapes throughout, with artwork created by York-based artist Dan Savage. At the end of September, shortly before the unit was fully operational, staff gathered to bury a time capsule which contains the history of care provided at the site for many decades. Patients moved into the new unit in late October 2023.

Photo: Her Grace Jane Percy, Duchess of Northumberland, officially opens the Sycamore Unit.

CNTW staff visit to Buckingham Palace

Mrs. Monica DSouza, a Clinical Nurse Educator in CNTW's International Recruitment and Relocation Support team, recently attended a Buckingham Palace reception hosted by King Charles to celebrate the contribution of nurses and midwives, especially those from international backgrounds. Monica was nominated to attend the reception by Victoria Bagshaw, Regional Nursing, Midwifery and Allied Health Professionals Lead for NHS England for the North East and Yorkshire region. Invitees were asked to wear traditional dress or smart clothing for the event – Monica wore the traditional Indian saree and the SHINE badge as the brooch.

Monica shook hands with King Charles and wished him well on his 75th Birthday, telling the King that she worked for CNTW and was originally from Mumbai, and they shared a joke about the Mumbai traffic. Representatives from every region and all the nursing associations in the UK attended the reception. Monica would like to extend her thanks to the Trust and NHS England for supporting her participation in this once-in-a-lifetime event.

Photos: Mrs DSouza outside Buckingham Palace, and meeting the King.

Trust's SHINE charity awarded funding from NHS Charities Together

The Trust's SHINE charity has been awarded a grant of £154,000 from NHS Charities Together. The grant is one of many thousands of awards made by NHS Charities Together thanks to its COVID-19 Urgent Appeal, which raised a massive £162 million.

The funding awarded to SHINE will go towards eight different projects aiming to support the long-term recovery of both patients and staff impacted by COVID-19 including bereavement support for staff provided by the Trust's Staff Psychological Centre, support for the carers of children and young people, and improving sensory rooms in children and young people's inpatient wards to support individuals with socialisation, sensory motor skills, cognitive development, and relaxation and recovery. A fully equipped sensory room will provide an alternative space for therapeutic sessions away from the ward environment.

The grant will also support services to access gardening equipment, make improvements to dining areas, access gym equipment and support the use of sessional workers. Projects were informed by feedback from service users and staff. The funding will enable a mural to be designed by a local artist to make dining spaces more welcoming in response to feedback from young people. It will also support events to promote family inclusion and build relationships between carers, patients and staff. Wellness packs will also be created for families and carers to support their wellbeing. Outdoor gyms will be created at Rose Lodge at Hopewood Park and Mitford at Northgate Hospital, part of the Trust's autism services.

The projects will begin in November 2023 and will run for two years.

Regional updates

NENC ICB releases first LeDeR report

The North East and North Cumbria Integrated Care Board has released its first Annual LeDeR report 'North East & North Cumbria Learning from the Lives and Deaths of People with Learning Disability and Autistic People Annual Report 2022 – 2023 (LeDeR)'. Key points include:

- During 2022/23 163 reviews were completed after the deaths of people with a learning disability. Of these, 128 were initial reviews and 35 focused reviews. 94 were men and 69 were women. The top three causes of death were pneumonia, cardiovascular disease and aspiration pneumonia.
- During 2022/23 4 reviews were completed following the deaths of autistic people. All were men and all were focused reviews (a LeDeR policy requirement). The causes of death were complications with drugs misuse, cardiovascular disease and suicide.
- Learning from reviews remains largely unchanged from previous years and the reasons people with a learning disability die early in the North East and North Cumbria are the same as the rest of England.
- The reviews of autistic people, a new addition to the LeDeR policy, take much longer to complete and reviewers are required to expand their skills and knowledge to ensure all learning is gathered. The reasons autistic people die early appear to be different from people with a learning disability although the numbers of completed reviews are very low. Further analysis of this will take place next year.

- End of life planning and an increase in uptake of annual health checks, flu and covid immunisation is playing a significant role in lengthening the lives of people with a learning disability.

Risks and concerns highlighted in ICB meeting papers include:

- The current number of reviewers will not enable compliance with current and future requirements and demands.
- Concern that reviews are tightly managed within a national KPI framework (all deaths require a review) although no new learning is being uncovered.
- Learning from reviews and associated improvement initiatives should be closely aligned with ICB work programmes, particularly the health inequalities, early intervention and prevention programmes.

The report will be considered for approval and subsequent publication at the 28th November ICB meeting.

National updates

Patient and Carer Race Equality Framework (PCREF) launch

NHS England launched the Patient and Carer Race Equality Framework (PCREF), a mandatory anti-racism framework for mental health trusts and providers in England. The PCREF was a key recommendation of the Independent Review of the Mental Health Act 2018. All mental health trusts must have their PCREF in place by the end of the financial year 2024/25 and progress towards delivering the framework will be assessed as part of Care Quality Commission (CQC) inspections. Each trust's PCREF must be fully co-produced with local racialised and ethnically and culturally diverse communities, with mental health providers responsible for the delivery of PCREF in collaboration with partners including local authorities, commissioners, communities, patients, and carers. PCREF will support trusts to become actively anti-racist organisations by reducing racial inequalities within their services, and applies to all mental health services and pathways and all patient age cohorts.

The PCREF will support improvement across three core domains: leadership and governance, national organisational competencies, and patient and carer feedback mechanisms. PCREF guidance sets out actions linked to the core domains which will enable trusts to embed an anti-racist approach:

1. Leadership and governance

- Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation.
- Co-develop, implement and review local PCREF plans with racialised communities and the workforce.
- Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans.

- Monitor core measures at Trust Board level on a regular basis and publish PCREF plans.

2. National organisational competencies

- Engage with racialised communities to identify and agree core organisational competencies.
- Agree on measurable and practical actions to co-develop in local PCREF plans.
- Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans.

3. Patient and carer feedback mechanism

- Ensure patient experience data is used, monitored and flowed to national datasets to enable benchmarking, lesson-sharing and service improvement.
- Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services.
- Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities.

Ethnic inequalities in IAPT access

The NHS Race and Health Observatory published Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT), an independent review of services provided by NHS Talking Therapies undertaken in partnership with the National Collaborating Centre for Mental Health. The report is based on 10 years of anonymised patient data and finds that while there is no evidence that talking therapies are unsuitable or ineffective for ethnic minority groups, people from Black and ethnic minority groups experience worse access to, and outcomes from, NHS talking therapies compared to White British groups. Other key findings include:

- In comparison with White British people, with the exception of Chinese people, people from minoritised ethnic groups (including non-British White people):
  - experienced worse outcomes, although this gap is narrowing.
  - waited longer for assessment.
  - were less likely to receive a course of treatment following assessment.
- Inequalities in outcomes for people from minoritised ethnic groups are associated with:
  - increased symptom severity at initial assessment.
  - living in areas with higher levels of deprivation, and higher unemployment.
  - waiting longer for assessment, and waiting longer between treatments.
- The IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide (PPG) published in 2019 was well received by services, but does not appear to be used consistently across services, and commissioners did not report good

knowledge of the PPG's recommendations when compared with IAPT staff and leads.

Young Carers and Young Adult Carers Inquiry

An inquiry by the All-Party Parliamentary Group on Young and Young Adult Carers has highlighted the devastating impact caring has on the life opportunities of the UK's young people. The inquiry has heard evidence from over 70 organisations and stakeholders and more than 400 young carers and young adult carers. Key findings from the Inquiry Report include:

- Some young carers have to wait 10 years before being identified. The average waiting time to be identified for support was three years.
- Being a young carer has a knock-on effect on school attainment and attendance, with young carers missing 27 school days per year on average.
- Young adult carers are substantially (38%) less likely to achieve a university degree than their peers without a caring role. Those caring for 35 or more hours a week are 86% less likely.
- Young adult carers are less likely to be employed than their peers without a caring role.
- Young people with caring responsibilities have a higher prevalence of self-harm. Of children who do self-harm, young carers are twice as likely to attempt to take their own life than non-carers.

The Inquiry Report makes a series of recommendations including:

- A cross-government National Carers Strategy with a dedicated section and resourced action plan relating to young and young adult carers.
- The Government should commission an independent 10-year review of the difference the Children and Families Act 2014 and Care Act 2014 have made for unpaid carers.
- The Government should work with young and young adult carers to set out its immediate plans to improve early identification, increase access to support for young carers and reduce the numbers providing inappropriate or excessive levels of care.
- The Government should formally support the development and implementation of the first UK-wide Covenant for Young Carers and Young Adult Carers.

Children and young people's mental health – new statistics

NHS Digital published the latest follow-up report to the 2017 Mental Health of Children and Young People (MHCYP) survey. The statistics explore the mental health of children and young people aged 8 to 25 years living in England in 2023, as well as their household

circumstances, experiences of education and services, and of life in their families and communities. Key findings include:

- In 2023, about 1 in 5 children and young people aged 8 to 25 years had a probable mental disorder.
- After a rise in prevalence between 2017 and 2020, rates of probable mental disorder remained stable in all age groups between 2022 and 2023.
- Among 8- to 16-year-olds, rates of probable mental disorder were similar for boys and girls, while for 17- to 25-year-olds, rates were twice as high for young women than young men.
- 26.8% of children aged 8 to 16 years with a probable mental disorder had a parent who could not afford for their child to take part in activities outside school or college, compared with 10.3% of those unlikely to have a mental disorder.
- 17- to 25-year-olds with a probable mental disorder were 3 times more likely to not be able to afford to take part in activities such as sports, days out, or socialising with friends, compared with those unlikely to have a mental disorder.
- Children aged 11 to 16 years with a probable mental disorder were 5 times more likely than those unlikely to have a mental disorder to have been bullied in person. They were also more likely to have been bullied online.
- Just over half of young people aged 17 to 25 years reported being worried about the impact of climate change.
- In 2023, eating disorders were identified in 12.5% of 17- to 19-year-olds, with rates 4 times higher in young women (20.8%) than young men (5.1%).

Public Accounts Committee highly critical of New Hospitals Programme

Parliament's Public Accounts Committee (PAC) has published a highly critical report highlighting extreme concern about the lack of progress in relation to the New Hospitals Programme (NHP), following the Government's 2020 commitment to build 40 new hospitals by 2030. Key findings include:

- The construction of 32 new hospitals is highly unlikely (the commitment to build all 40 was abandoned in May). The PAC is calling for the Department for Health and Social Care (DHSC) to urgently examine how the NHP can be made to deliver some tangible results for patients.
- If rebuilding of the seven hospitals constructed entirely of reinforced autoclaved aerated concrete (RAAC) is not sped up, some hospitals may have to close before replacements are ready. The report makes a number of recommendations to support quicker action to tackle RAAC in hospital buildings.
- The underlying cause of the NHS's record maintenance backlog is the raiding of capital budgets for day-to-day spending. Government has failed to consider the long-term consequences for services and patient care of diverting billions of pounds in this way.

- There currently appears to be insufficient funding for DHSC to build all the hospitals it plans, to an adequate size, by 2030.
- Current plans are based on unrealistic assumptions - that increasing demand for care from a growing and ageing population can be tackled by high levels of bed occupancy (95%), large reductions in patients' average length of hospital stay, and a significant, recurring 1.8% per annum transfer of patient care out of hospitals into the community. Making these assumptions more realistic is likely to increase the cost of new hospitals and require a further reset of the NHP.

Autumn Statement

Chancellor Jeremy Hunt presented his Autumn Statement to the House of Commons this week, setting out the Government's tax and spending plans for the year ahead. Key announcements include:

- There were no new major funding announcements for healthcare, and existing settlements will remain the same in cash terms:
  - £200 million of new funding announced in September 2023 to boost NHS resilience.
  - Funding the non-consolidated payment for 2022/23 for Agenda for Change equivalent staff.
  - More medical places starting in September next year in line with the NHS Long Term Workforce Plan.
- There will be increased support to help those who have mental health issues to find work, including by digitising the NHS Health Check. Building on the announcement from the Spring Budget, the government announced support for an additional 100,000 people to access Individual Placement Support over the next five years.
- NHS Talking Therapies (previously IAPT) will also be expanded so an additional 384,000 people can access psychological therapies within five years.
- Main rate of National Insurance cut from 12% to 10% from 6 January.
- Legal minimum wage - known officially as the National Living Wage - to increase from £10.42 to £11.44 an hour from April. The new rate will apply to 21 and 22-year-old workers for the first time, rather than just those 23 and over.
- Universal credit and other working-age benefits in England and Wales to increase by 6.7% from April, in line with September's inflation rate.
- Claimants in England and Wales deemed able to work who refuse to seek employment will lose access to their benefits and extras like free prescriptions.
- State pension payments will increase by 8.5% from April, in line with average earnings.
- The independent Office for Budget Responsibility (OBR) forecasts that inflation will fall to 2.8% by the end of 2024, before reaching the Bank of England's 2% target rate in 2025.

- Living standards are not expected to return to pre-pandemic levels until 2027-28.

The NHS Confederation has published a briefing analysing the implications of the Autumn Statement for the health and care sector.

8. INTEGRATED PERFORMANCE REPORT MONTH 7

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

8a. Board Cover Sheet - IPR - Month 7.pdf

8b. BoD - IPR Trust Report - Month 7.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6th December 2023
Title of report	Integrated Performance Report Month 7
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		Management meetings where this item has been considered	
Quality and Performance		Executive Team	
Audit		Executive Management Group	27.11.23
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	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

With YOU in mind

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)

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2023-24 Month 7 (October 2023)

With YOU in mind

Integrated Performance Report - Headline Commentary

Headline Challenges

- **Commitments to our Carers & Patients –** All 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.
- **Appraisal Rates and Clinical Supervision rates –** both off track significantly and consistently, despite gradual improvement.
- **Serious Incidents -** Despite the low numbers, the incidents are of serious magnitude, so an exception report is included.
- **CPA Completed Review –** Off the 95% target at 88..9%, however, there has been an improvement of 9% in 2 months.
- **Staff fill rates –** off target significantly last two month.
- **Clinically Ready for Discharge/ Bed Occupancy -** Off track
- **Crisis Very Urgent Referrals seen within 4 hours –** At 46.7%, has not improved for several months
- **Psychiatric Liaison Referrals in ED within 1 hour –** Benchmarks low across the region, has improved last 2 months
- **New (from Jul-23) 4-week national standard waiting times:**
  - **% waiting < 4 weeks to Treatment Adult and Older Adult Waits to Treatment** – 23.8% of referrals have been waiting 4 weeks or less to treatment.
  - **% waiting < 4 weeks to Receive Help - All CYPS** – 12.6% of referrals have been waiting 4 weeks or less to receive help.
  - **% waiting < 4 weeks to Receive Help - CYPS Neuro Developmental** – 9.1% 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 7. 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) –** Remains consistently above the 95% standard
- **CYPS Eating Disorders (Routine Referrals)** – Reported above standard for the first time in 24 months
- **Long term segregation and seclusion** – Decreased in the month.
- **CPA Completed Review –** Continued increase seen in the month
- **Risk Assessment** – Above standard for second consecutive month
- **Out of Area Placements** – Lowest number of reported inappropriate Out of Area Bed Day in 24 months and reported below the trajectory.
- **Bed Occupancy** – Improvement in the month, best position reported for 20 months.
- **Psychiatric Liaison Referrals in ED within 1 hour and 24hr on wards** – Both measures showing increased performance in month
- **Talking Therapies % Moving to Recovery** – Reported above standard
- **Live within our means** – Lowest agency spend this financial year in month

Mitigations/actions

- **% of Training Compliance (Courses with a standard) –** To improve the focus in priority areas for operational teams, training measures are being prioritised into mandatory, essential and desirable. This will also include prioritising certain teams and job roles. Prioritisation has already taken place for the PMVA training to ensure that LD, Autism, CYPS, Adult Acute and Secure Wards reach the 85% target by the end of Q4 23/24. This is to ensure the high-risk areas for violence and aggression are prioritised to support patient and staff safety and reduce harm. *Recovery plan in place*
- **Crisis Very Urgent Referrals seen within 4 hours** - Significant improvement work in place. Localities are reporting on operational performance and recovery actions. There is a working group to oversee the successful implementation of the new standards for Crisis including, improving the processes, recording and implementation of a new dashboard. The Urgent Care and Inpatient programme is reviewing the current position on the crisis work, 136-suite flow, alternatives to admission, community interface, discharge model/in-reach and the development of 111 for Mental Health. *Recovery plans in place & review of transformation milestones planned*
- **Psychiatric Liaison Referrals in ED within 1 hour –** An internal review of Psychiatric Liaison Services has identified areas to incorporate into the improvement action plan. A report was received by the Quality and Performance Committee with full details on the recommendations. *Recovery plan in place*
- **% waiting less than 4-week (new standard)-** The final redesigned pathway for CYPS Neurodevelopmental was presented to the Community Oversight Group on 26th October 2023. Further refinement required by early November prior to presentation to BDG in December. 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 plan 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 on the Trust financial position and locality forecast positions in year. *Recovery plan being developed*

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Oct 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	85.5%	95.0%	Internal	High (Action)	Not on target but has improved in the month	SR
	C02	Did we listen to you? (PoY)	Normal Variation	Consistently Fail	84.1%	95.0%	Internal	High (Action)	Not on target but has improved in the month	SR
	C03	Were staff kind and caring? (PoY)	Normal Variation	Achieve at Random	92.4%	95.0%	Internal	Med (Monitoring)	Not on target but has improved in the month	SR
	C04	Did you feel safe? (PoY)	Normal Variation	Achieve at Random	89.0%	95.0%	Internal	Med (Monitoring)	Not on target but has improved in the month	SR
	C05	Were you given helpful information? (PoY)	Normal Variation	Consistently Fail	83.6%	95.0%	Internal	High (Action)	Not on target but has improved in the month	SR
People	P01	Turnover	Normal Variation	Achieve at Random	10.6%	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)	Off target but remains stable reported 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	75.6%	85.0%	Internal	High (Action)	After a year of improvement this has deteriorated over 3 months	LS
	P05	% Clinical Supervision completed	Improvement	Consistently Fail	55.4%	80.0%	Internal	High (Action)	Off target. Gradual improvement. Last 8 months 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	Normal Variation	No Standard	23	No Std	No Plan	Low (No Standard)	Decreased in the month	SR
	Q02	Serious Incidents	Normal Variation	No Standard	17	No Std	No Plan	High (Action)	Despite low numbers, action is required due to magnitude	RN
	Q03	Harm Incidents	Normal Variation	No Standard	1,794	No Std	No Plan	Low (No Standard)	Increased in the month, reported within expected range	RN
	Q04	Safeguarding and Public Protection (SAPP)	Normal Variation	No Standard	1,306	No Std	No Plan	Low (No Standard)	Decreased in the month, reported below average	RN
	Q05	Long term segregation and prolonged seclusion	Normal Variation	No Standard	12	No Std	No Plan	Low (No Standard)	12 out of last 13 months reported better than average	SR
	Q06	Aggression and Violence	Normal Variation	No Standard	1,418	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	77	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	95.4%	95.0%	Internal	Low (On Track)	Reported above standard for the first time in 16 months	SR
	Q10	CPA Completed review	Normal Variation	Consistently Fail	88.9%	95.0%	Internal	High (Action)	Remains below standard but steady increase in the month	SR
	Q11	Staffing fill rates	Normal Variation	Achieve at Random	141.5%	120.0%	National	High (Action)	Reported above standard	SR
Person Led Care	A01	Out of Area Placement bed days	Normal Variation	Achieve at Random	39	155	LTP	High (Action)	Significant improvement in month, well within trajectory	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Improvement	Consistently Fail	91.3%	85.0%	National	High (Action)	Improved in the month, remains above the optimal level of 85%	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	No Standard	21.2%	No Std	No Plan	Low (No Standard)	Improved in the month within expected range	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	No Standard	42.1%	No Std	No Plan	Low (No Standard)	Deteriorated in the month within expected range	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Consistently Fail	11.4%	7.5%	National	High (Action)	Deteriorated in month below upper control limit	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	No Standard	46.7%	No Std	No Plan	Med (Monitoring)	50 of 107, less than half of Very Urgent Crisis patients seen in 4hrs	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Concern	No Standard	82.1%	No Std	No Plan	Med (Monitoring)	357 out of 435. Performance improved in the month	RD
	A08	% PLT ED Referrals seen within 1 hour	Normal Variation	No Standard	63.5%	No Std	LTP	Med (Monitoring)	Significantly improved in last two months	RD
	A09	% PLT Ward Referrals seen within 24 hours	Improvement	No Standard	87.4%	No Std	LTP	Low (No Standard)	Significantly improved in last two months	RD
	A10	72 hour Follow-Up	Normal Variation	Consistently Achieve	92.3%	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	23.8%	No Std	No Plan	High (Action)	76.2% (3,264 of 4,282) have been waiting longer than 4 weeks	RD
	A12	% Waiting 4 wks or less to receive help (CYPS)	SPC N/A	No Standard	12.6%	No Std	No Plan	High (Action)	87.4% (4,433 of 5,073) have been waiting longer than 4 weeks	RD
	A13	% Waiting 4 wks or less to receive help (CYPS Neuro)	SPC N/A	No Standard	9.1%	No Std	No Plan	High (Action)	90.9% (4,071 of 4,479) 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 exceeds 95% standard	RD
	A15	CYPS Eating Disorders (routine referrals)	Normal Variation	Achieve at Random	96.2%	95.0%	LTP	Med (Monitoring)	Standard achieved for the first time in 24 months	RD
	A16	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	97.1%	60.0%	LTP	Low (On Track)	Significant improvement in performance	RD
	A17	Talking Therapies % Moving to Recovery (IAPT)	Normal Variation	Achieve at Random	51.6%	50.0%	LTP	Low (On Track)	Improved in month, remains above standard	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC N/A	SPC N/A	-0.2M	-0.2M	No Plan	High (Action)	23/24 forecast under significant pressure	KS
	S02	Capital spend compared to plan (£)	SPC N/A	SPC N/A	1.0M	1.2M	No Plan	Low (On Track)	Capital programme overcommitted	KS
	S03	Cash balance compared to plan (£)	SPC N/A	SPC N/A	32.3M	20.4M	No Plan	Low (On Track)	Cash balance on plan due to additional monies	KS

Commitments to our Carers & Patients - Headline Commentary

Headline Challenges

- **How was your experience? (FFT) –** At 85.5% this continues not to meet the 95% standard but is an increase on the previous month (83.7%). The latest national published FFT score for England is reported at 87% (September 23 remaining the same as August 23).

Points of You Questions (PoY)

- **Did we listen to you?** - At 84.1% this remains below standard but has increased (previously 83.2%).
- **Were staff kind and caring?** – At 92.4% this represents an improvement on the previous month and is the best performing score for PoY questions. (90.5% in August 23)
- **Did you feel safe?** - At 89% this remains below standard but is an improvement on the previous month (87.9%).
- **Were you given helpful information?** - At 83.6% (August 83.6%) this continues to be a low scoring question. 43 people said they did not receive helpful information, the majority were in relation to adult community and inpatient services (29).

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

Promoting feedback options to service users and carers has remained a high priority. This month has seen the highest recorded level of feedback for a month through PoY.

124 teams received feedback and 49 (40%) of them produced You Said – We Did posters, which offer the opportunity to let service users, carers and staff know how this feedback has been responded to. This is the highest number of posters produced in a month to date.

Mitigations/actions

How was your experience? (FFT)

- This is discussed at the Service User and Carer Reference Group and Locality Involvement and Experience Groups.
- A review of current internal reporting against national methodology is being undertaken to ensure consistent reporting. Internal reporting needs to align to replicate 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.

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.
- The most recent service user and carer experience report highlighted areas where people feel least safe. This has been discussed in recent EMG and Board meetings.

Were you given helpful information? (PoY)

- Carers Together Group has reviewed all the carer information. The Carer Promise, Carer Card and Useful Contacts leaflets have been approved and circulated to all services. The Checklist for Carers leaflet is still to be finalised and approved by the Group.

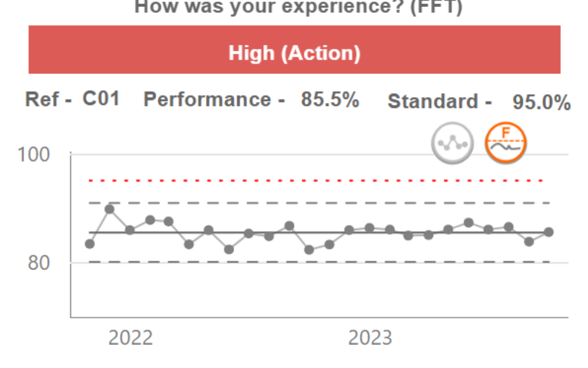
Commitments to our Carers & Patients

Reporting Period: Oct 2023

How was your experience? (FFT)

High (Action)

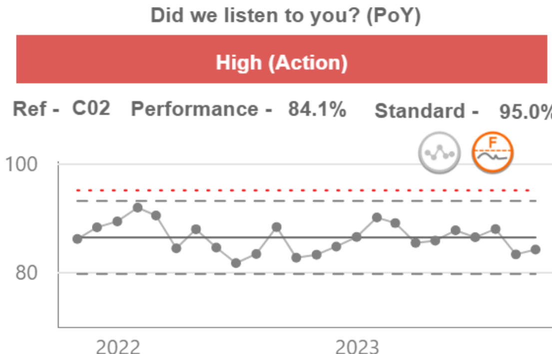
Ref - C01 Performance - 85.5% Standard - 95.0%



Did we listen to you? (PoY)

High (Action)

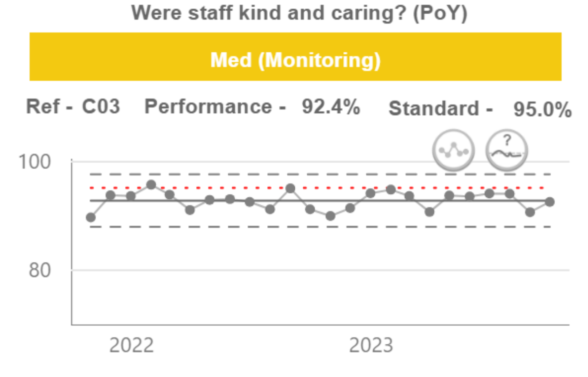
Ref - C02 Performance - 84.1% Standard - 95.0%



Were staff kind and caring? (PoY)

Med (Monitoring)

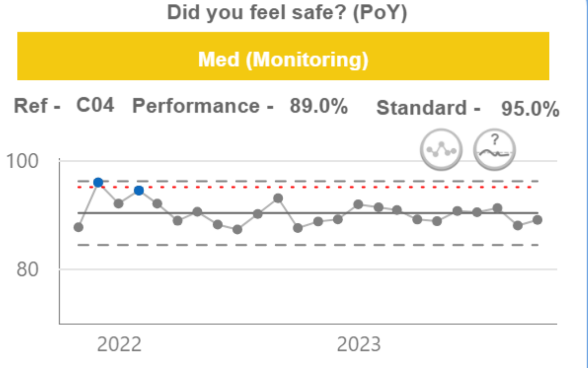
Ref - C03 Performance - 92.4% Standard - 95.0%



Did you feel safe? (PoY)

Med (Monitoring)

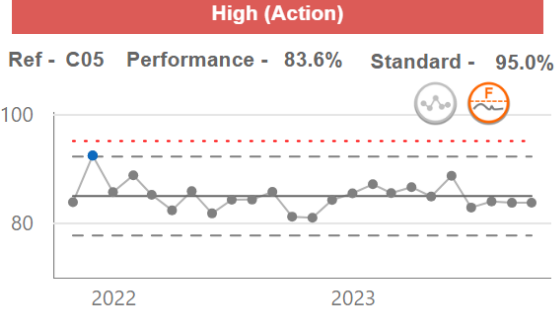
Ref - C04 Performance - 89.0% Standard - 95.0%



Were you given helpful information? (PoY)

High (Action)

Ref - C05 Performance - 83.6% Standard - 95.0%



Great Place to Work - Headline Commentary

Headline Challenges

- **Sickness** – The confirmed sickness within the report relates to September and is reported at 6.6%. There has been an increase in Covid related absence in the month. The provisional sickness for October 2023 is 6.85%.
- **% of Training Compliance (Courses with a standard)** – In October, 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 to deliver training (PMVA).
- **Clinical Supervision** – Performance still under compliance standard, however we continue to see a positive improvement as seen in 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 / Appraisals –** longer term improvement in both these measures despite recent fluctuations in performance
- **% of Training Compliance (Courses with a standard) -** Continuous proactive engagement with services around priority training including Information Governance, Fire and Safeguarding training.

Mitigations/actions

Sickness

- Continued support in management of short-term and long-term absence. To keep staff well at work and signposting support and developing 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
- Developing plan to expand training and support for Domestic Violence and line manager awareness.
- Promotion of Health Champion training.

% of Training Compliance (Courses with a standard)

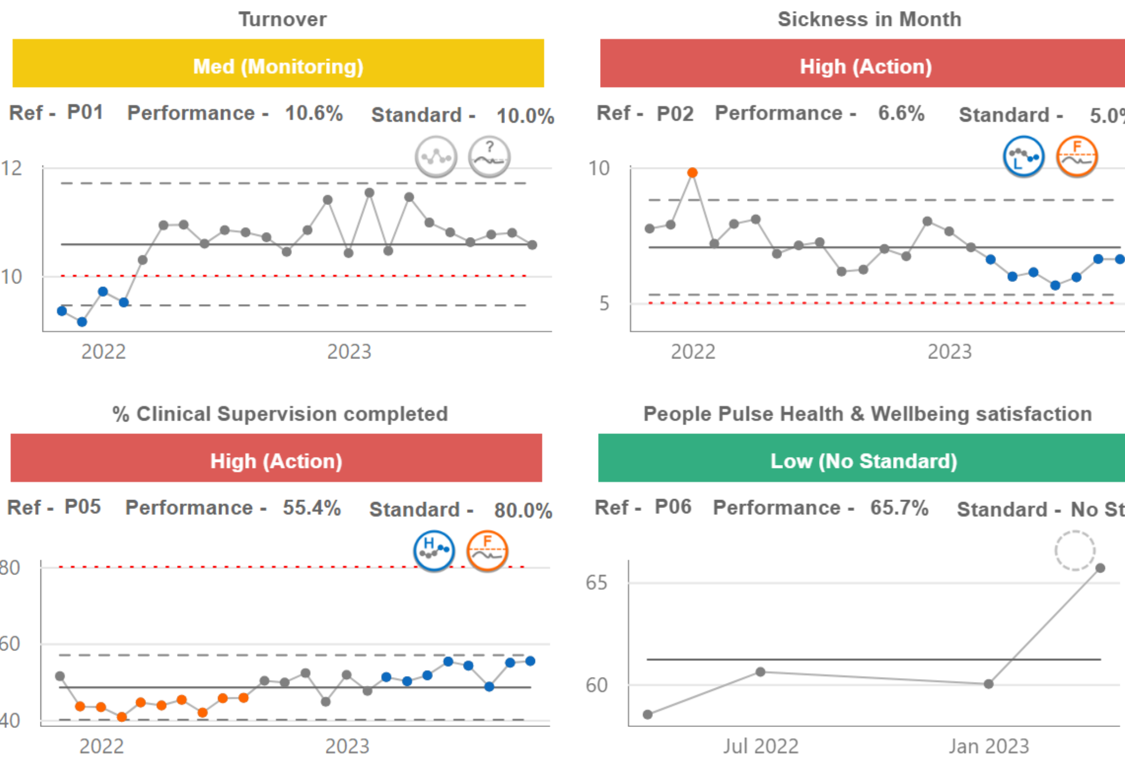
- To improve the focus in priority areas for operational teams, training measures are being prioritised into mandatory, essential and desirable. This will also include prioritising certain teams and job roles. Prioritisation has already taken place for the PMVA (Prevention and Management of Violence & Aggression) training to ensure that LD, Autism, CYPS, Adult Acute and Secure Wards reach the 85% target by the end of Q4 23/24. This is to ensure the high-risk areas for aggression and violence are prioritised to support patient and staff safety and reduce harm. *Recovery plan in place*

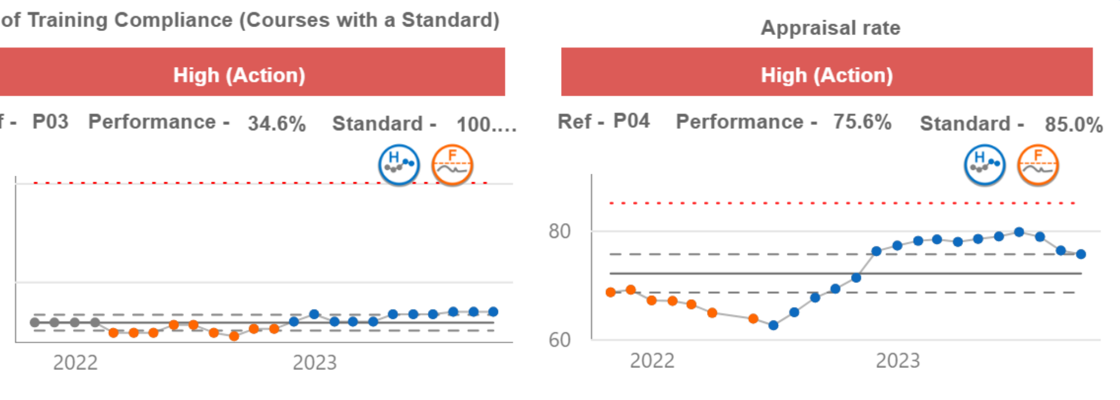
Clinical Supervision

- Directive for Clinical Supervision to be a priority focus as a CQC must do.
- Monitored through local CBU meetings, 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: Oct 2023





Quality Care, Everyday - Headline Commentary

Reporting Period: Oct 2023

Headline Challenges

- **Restrictive Intervention Incidents** –Decreased in the month
- **Serious Incidents** – The number of Serious Incidents has decreased this month and 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 fourth consecutive month.
- **Staffing Fill Rates -** Reporting is 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 remaining high.
- **CPA Complete Review** – Performance increased to 88.9%, the target is 95%, however this performance may be impacted by the transformation work which is currently underway
- **Care Plan Compliance** – Current performance is 94.4%, the target is 95%. Remaining stable in 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 – Remaining stable

Risk Assessment – Reported above standard for the first time in 16 months

CPA Completed Reviews – Continued increase in performance in the month

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. Learning is shared through various forums including locality safety and quality meetings, learning lessons groups, Trust and Safer Care bulletins.

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 being trialled to better understand potential issues

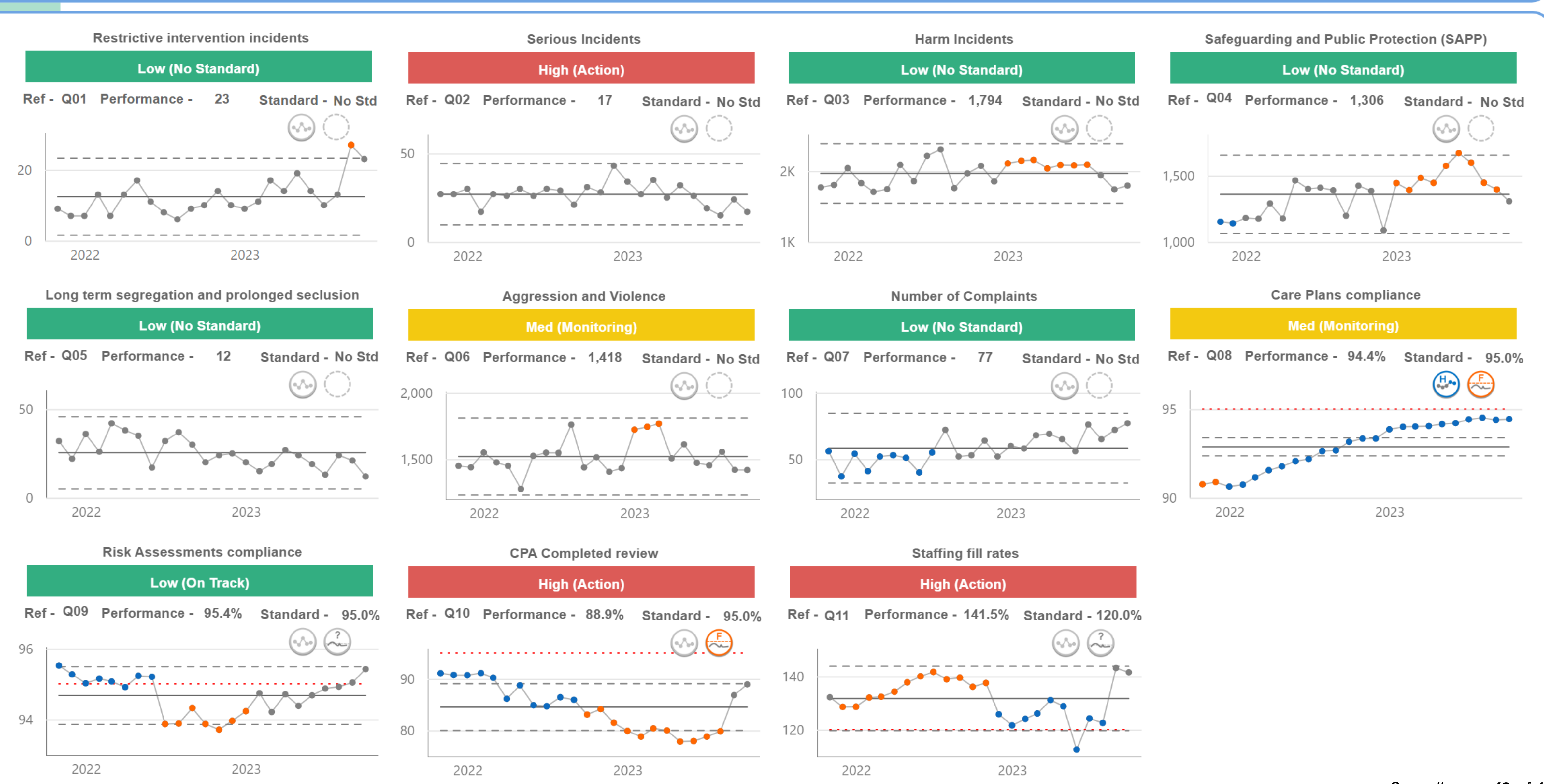
Staffing Fill Rates – Inpatient Staffing – Enhanced MDT Model work is progressing as part of the Urgent Care Programme Board. The outcome will produce a revised skill mix model for Adult Acute wards. Timeframe for completion end of Q3

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.
- Continued dedicated focus within Commissioning and Quality Assurance Data Quality staff to review RiO and update records accordingly if reviews have been completed and liaise with clinicians to support compliance.

Quality Care, Everyday

Reporting Period: Oct 2023



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

Headline Challenges

- **Clinically Ready for Discharge –** has deteriorated in the last few months
- **Bed Occupancy –** Off target consistently but improved over last 5 months
- **Crisis Very Urgent Referrals seen within 4 hours** At 46.7%, has not improved for several months
- **Psychiatric Liaison Referrals in ED within 1 hour** Benchmarks low across the region, has improved last 2 months
- **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** – 23.8% of referrals have been waiting 4 weeks or less to treatment.
  - **% waiting < 4 weeks to Receive Help - All CYPS** – 12.6% of referrals have been waiting 4 weeks or less to receive help.
  - **% waiting < 4 weeks to Receive Help - CYPS Neuro Developmental** – 9.1% of referrals have been waiting 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 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**

Positive Assurance / Improvement

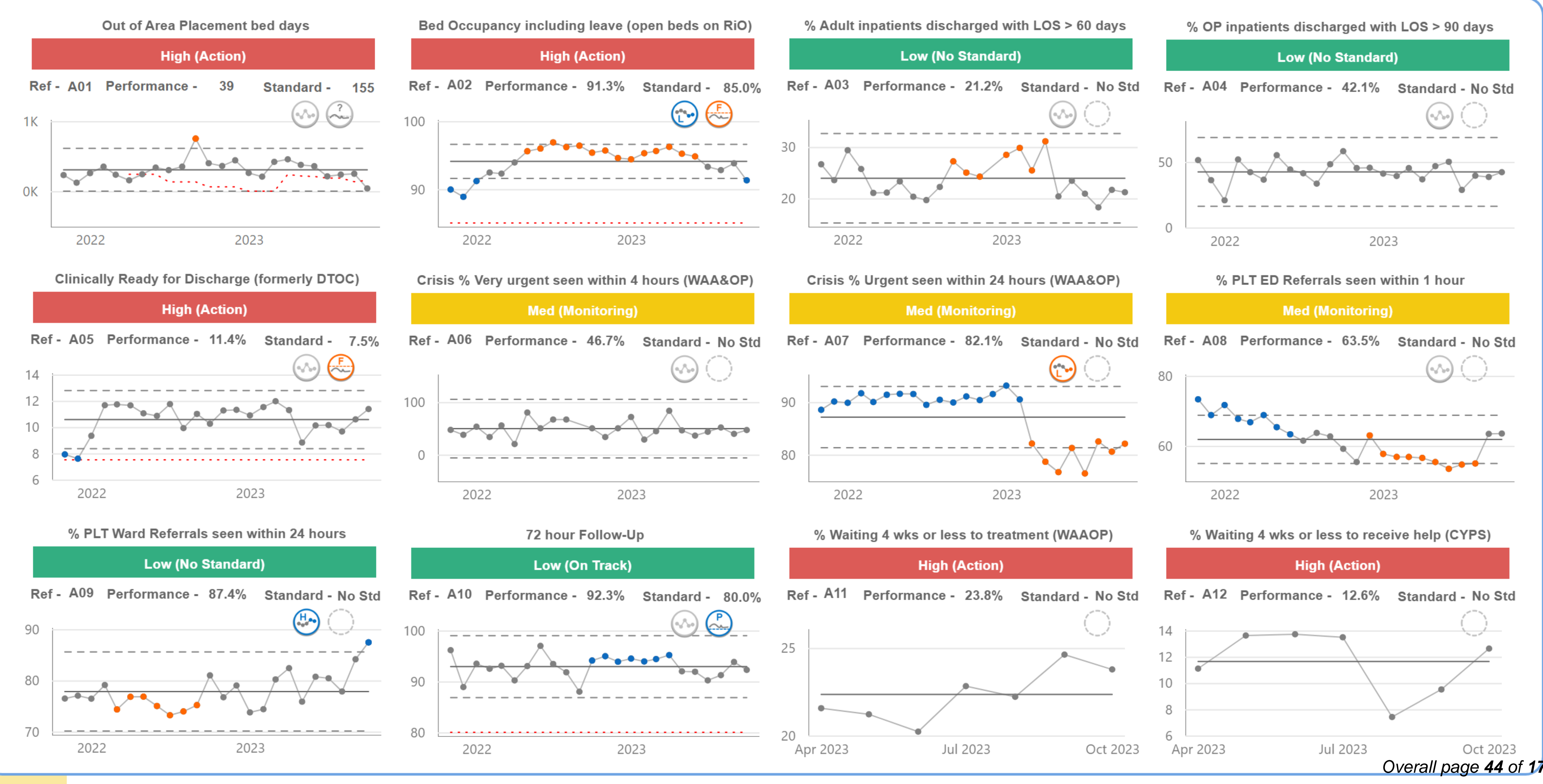
- **EIP (Early Intervention Psychosis) -** Consistently above standard.
- **72 hour follow up -** Remains consistently above the 80% standard.
- **CYPS Eating Disorders (Urgent Referrals) –** Remains consistently above the 95% standard
- **CYPS Eating Disorders (Routine Referrals)** – Reported above standard for the first time in 24 months
- **Out of Area Placements** – Lowest number of reported inappropriate Out of Area Bed Day in 24 months and reported below the trajectory.
- **Bed Occupancy** – Improvement in the month, best position reported for 20 months.
- **Psychiatric Liaison Referrals in ED within 1 hour and 24hr on wards** – Both measures showing increased performance in month
- **Talking Therapies % Moving to Recovery** – Reported above standard

Mitigations/actions

- **Crisis Very Urgent Referrals seen within 4 hours** - Significant improvement work in place. Localities are reporting on operational performance and recovery actions. There is a working group to oversee the successful implementation of the new standards for Crisis including, improving the processes, recording and implementation of a new dashboard. The Urgent Care and Inpatient programme is reviewing the current position on the crisis work, 136-suite flow, alternatives to admission, community interface, discharge model/in-reach and the development of 111 for Mental Health. *Recovery plans in place & review of transformation milestones planned*
- **Psychiatric Liaison Referrals in ED within 1 hour –** An internal review of Psychiatric Liaison Services has identified areas to incorporate into the improvement action plan. A report was received by the Quality and Performance Committee with full details on the recommendations. *Recovery plan in place*
- **% 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: Oct 2023



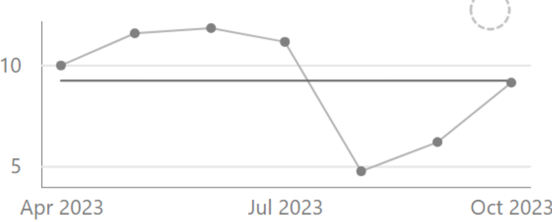
Person Led Care, when and where it's needed

Reporting Period: Oct 2023

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

High (Action)

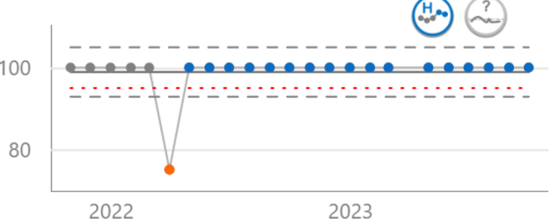
Ref - A13 Performance - 9.1% Standard - No Std



CYPS Eating Disorders (urgent referrals)

Low (On Track)

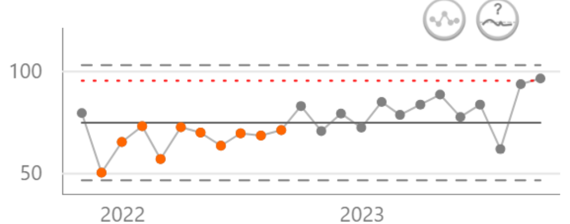
Ref - A14 Performance - 100.0% Standard - 95.0%



CYPS Eating Disorders (routine referrals)

Med (Monitoring)

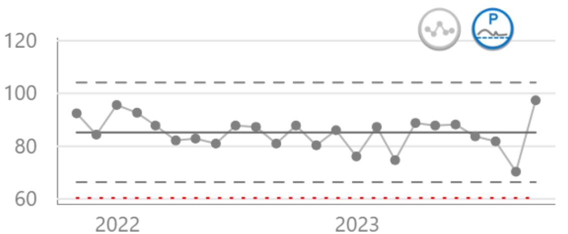
Ref - A15 Performance - 96.2% Standard - 95.0%



EIP – starting treatment in 14 days

Low (On Track)

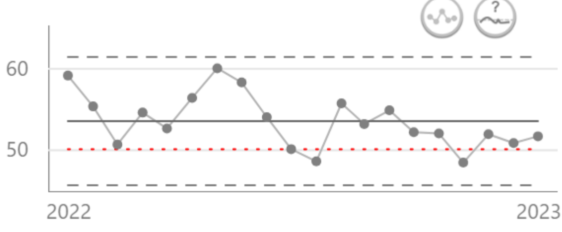
Ref - A16 Performance - 97.1% Standard - 60.0%



Talking Therapies % Moving to Recovery (IAPT)

Low (On Track)

Ref - A17 Performance - 51.6% Standard - 50.0%



Sustainable for the Long Term - Headline Commentary

Headline Challenges

- The Trust is reporting a £5.4m deficit at month 7 which is £0.2m 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 year to date position includes a £5.8m gain on disposal following the agreement of the sale of land at Northgate.
- At the end of month 7 the Trust has spent £10.2m on agency staff against a plan £9.8m and against the Trust's nationally applied agency ceiling of £8.4m.
- 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. The Trust has financial pressure in all four inpatient CBUs.
- The Trust financial plan includes gains on disposal of land. The Trust forecast includes gains on disposal of 2 land sales. 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 to £32.3m at month 7 and will continue to come under pressure from continued monthly deficits. Month 7 is the first month where the Trust cash balances are less than 1 months' pay costs.
- A revised capital programme has been proposed and approved within the Trust.
- Trust underlying financial position - planning 24/25

Positive Assurance / Improvement

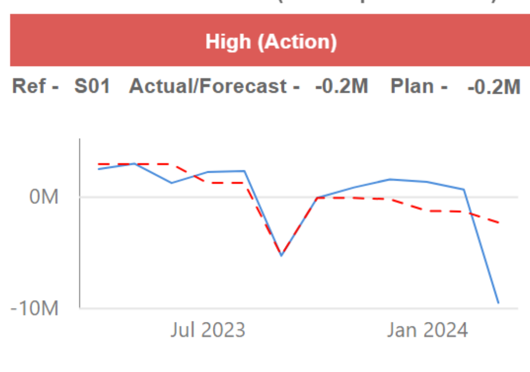
- Trust current cash balances are over plan from slippage in capital programme and PDC secured at the end of 22/23 but remain a concern.
- Senior Management commitment to improve financial position – focus of BDG on a monthly basis with specific financial reviews of areas of most concern
- Monthly agency spend at month 7 is the lowest this financial year at £1.26m which is on a continued downward trend. The Trust is forecasting this to reduce to £1.1m a month by Q4.

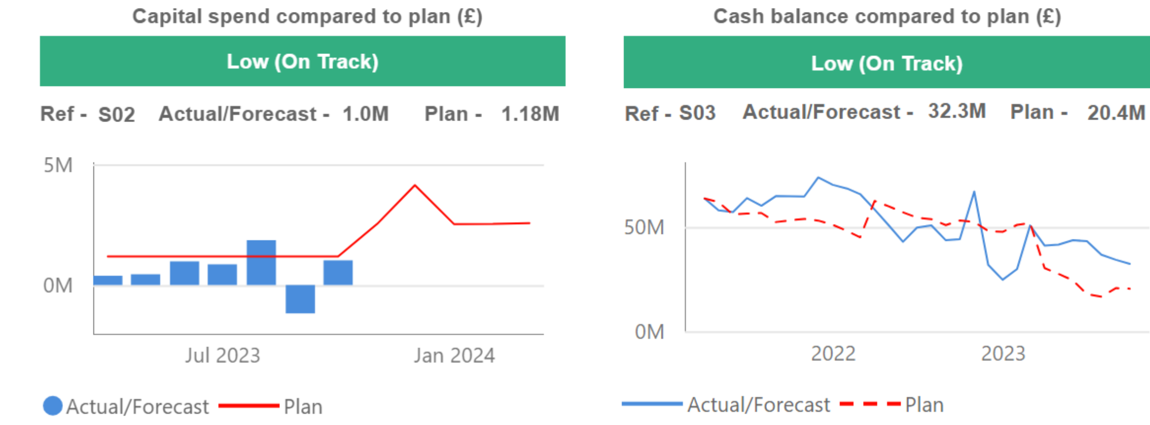
Mitigations/actions

- 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.
- Shortfall in delivery of recurrent Cost Improvement Schemes is being offset with non-recurrent mitigations including release of the Annual Leave provision. Interest on cash balances from increased interest rates and further reviews of balances sheet totals.
- Pursing capital funding for CEDAR scheme to support Trust cash balances.

Sustainable for the Long Term

Reporting Period: Oct 2023





C01 - How was your experience? (FFT)

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

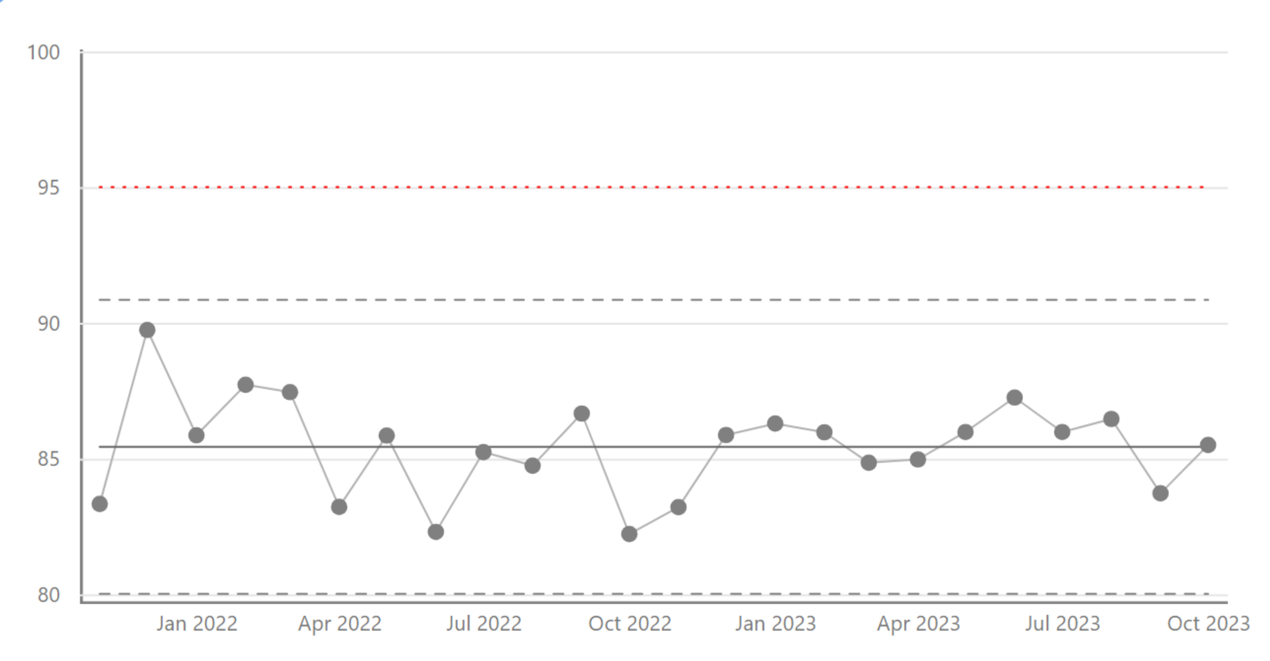
Risk Rating - **High (Action)**

Performance - 85.5%
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	79.2%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	85.9%	95.0%	Improvement	Achieve at Random
South Locality Care Group	87.9%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 85.5% for October was within the expected range of 80% to 91% which remains below the standard of 95%, which will not be met without change.

Root Cause of the performance issue

The Trust remains reliant on people receiving a survey shortly after discharge and currently only around 8% of people offered choose to complete and return the survey.

Availability of information (31 comments) and being listened to (28 comments) were the most common themes for negative comments.

Improvement Actions

Teams should develop a strategy that suits the needs of their service users and carers that promotes feedback to be offered by more people. Efforts to make sure marginalised groups and those who might need support to complete a survey should be considered.

Making sure appropriate and supportive information is available and supporting service users and carers to feel listened to would reduce the likelihood that this continues as a dominant negative theme in feedback.

The Trust Level Service User and Carer Reference Group and Locality Level service user and carer forums provide a platforms for staff to inform, listen and provide information.

Internal reporting needs to align to replicate national methodology.

Expected impact and by when

Improvement towards the standard and increased feedback received during 23-24.

C02 - Did we listen to you? (PoY)

Risk Rating - **High (Action)**

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

Performance - 84.1%

Standard - 95.0%

Consistently Fail

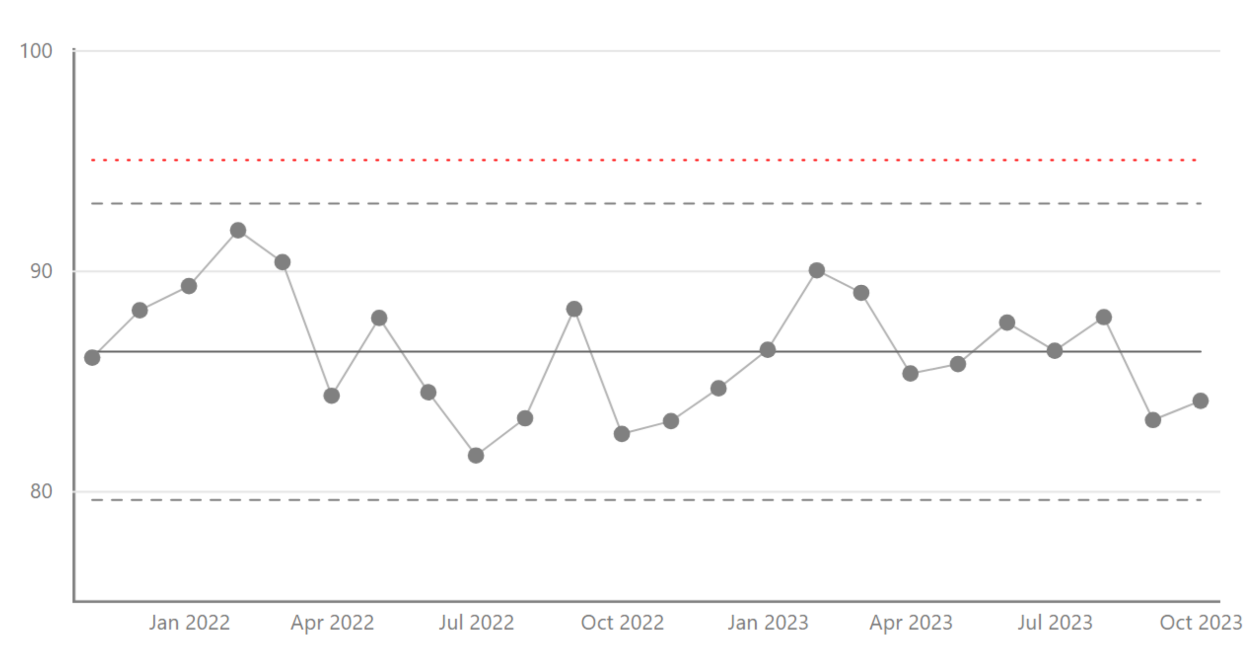
The standard for this indicator is outside the control limits

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	85.5%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	80.6%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	79.5%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	88.8%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 84.1% for October was within the expected range of 80% to 93% which remains below the standard of 95%.

Root Cause of the performance issue

36 of the 555 people who answered this question did not feel listened to. The trend is for less people to not to feel listened to, however when people answered no, this was in relation to adult community and inpatient services.

Improvement Actions

- Very few staff access the PoY dashboard with any regularity, meaning many teams are not aware of trends in feedback for their specific team. Making accessing this information part of everyday business would support teams to be responsive.
- A record number of teams (49) created You Said – We Did posters. This is a good way of showing service users and carers that their feedback is listened to.

Expected impact and by when

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

C03 - Were staff kind and caring? (PoY)

Risk Rating - **Med (Monitoring)**

Were staff kind and caring? (PoY)

Performance - 92.4%

Standard - 95.0%

Achieve at Random

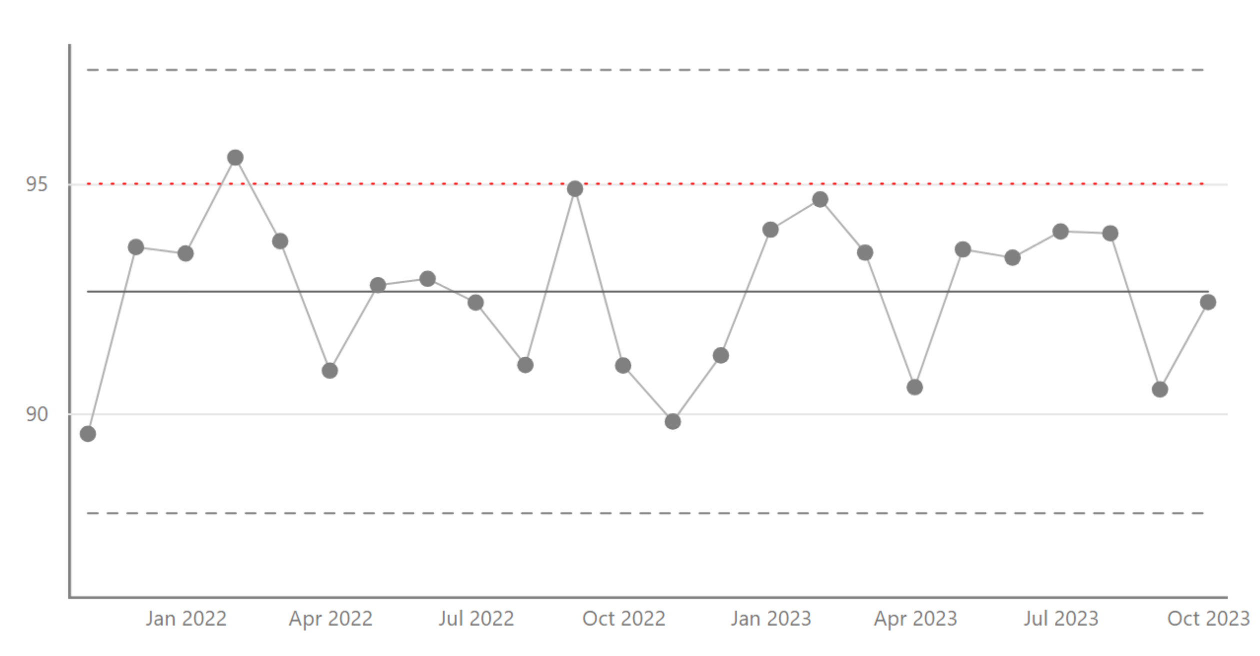
The standard for this indicator is within the upper and lower control limits

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	91.6%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	92.7%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	90.2%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	94.7%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 92.4% for October 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, 10 times this month.

Improvement Actions

- As this is something staff are clearly doing very well, it would be supportive to the workforce to let them know that service users and carers overwhelmingly believe they are kind and caring. Efforts to cascade this information should be made in groups, CBUs and individual teams.
- You Said – We Did posters continue to be produce by more teams, continuing this trend would promote more service users and carers to know the Trust cares about their opinions of services.

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 - 89.0%

Standard - 95.0%

Achieve at Random

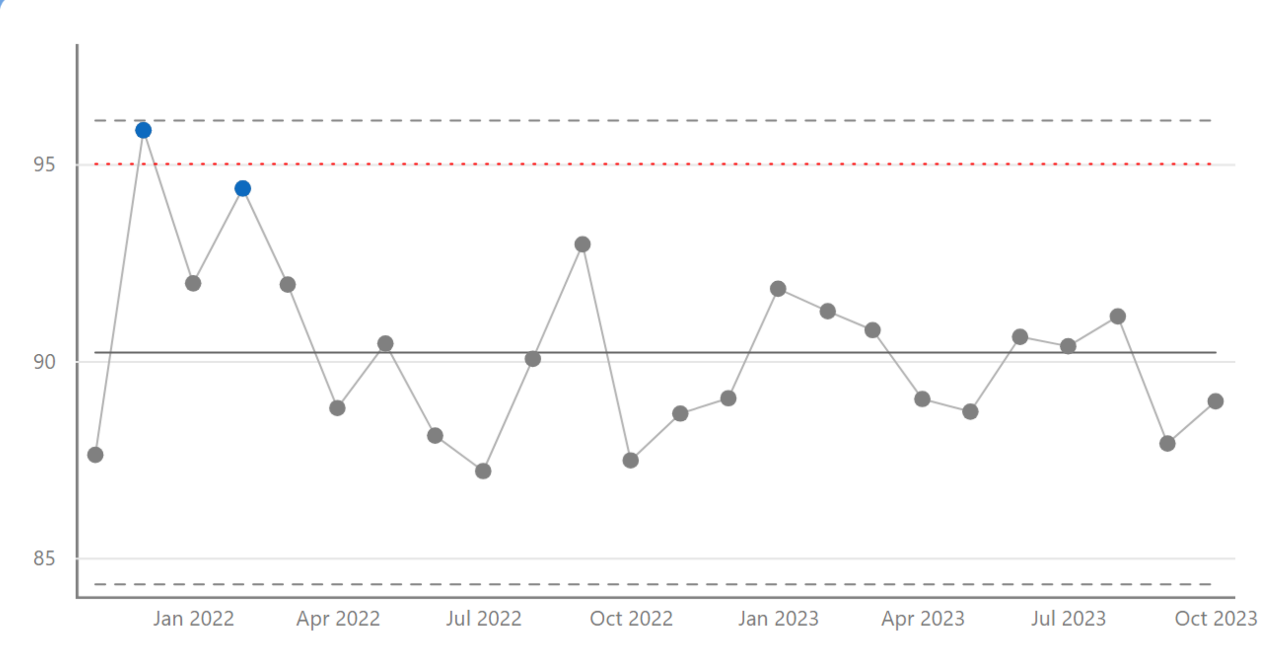
The standard for this indicator is within the upper and lower control limits

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	88.4%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	86.8%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	86.0%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	92.2%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 89% for October 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

- 35 people reported not feeling safe during October, an increase on the previous month (22 people).
  - Adult community mental health services had the most people say they didn't feel safe (9 people)
  - Adult PICU was the 2nd most common place for people reporting they didn't feel safe (8 people)
- 496 people reported feeling safe, an increase on the previous month (356 people).
  - Community based mental health services for older adults had the most people say they felt safe (111 people)

Improvement Actions

- Teams to access 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

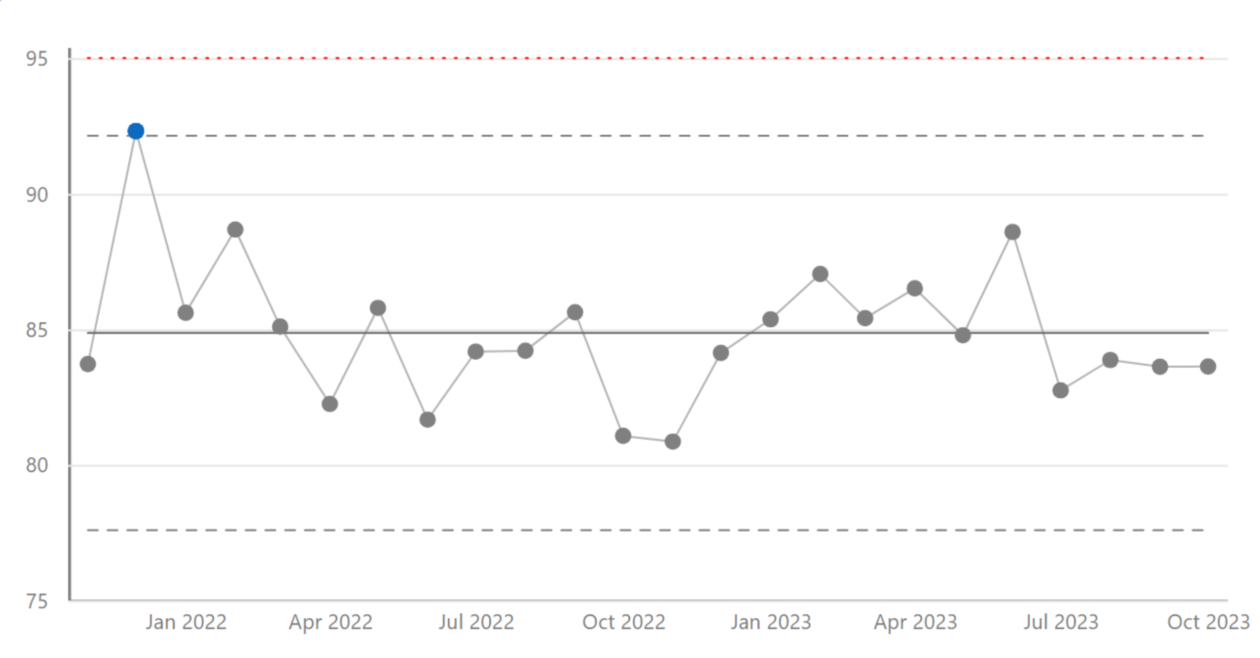
The standard for this indicator is outside the control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

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



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	83.7%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	80.3%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	81.4%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	87.3%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 83.6% for October was within the expected range of 77% to 92% 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.
- Service users and carers that needed to find their own information about the illness affecting them

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 has reviewed all the carer information. The Carer Promise, Carer Card and Useful Contacts leaflets have been approved and circulated to all services. The Checklist for Carers leaflet is still to be finalised and approved by the Group.

Expected impact and by when

- Throughout 2023-24

P01 - Turnover

Turnover FTE 12 month rolling

Risk Rating - **Med (Monitoring)**

Performance - 10.6%
Standard - 10.0%

Achieve at Random

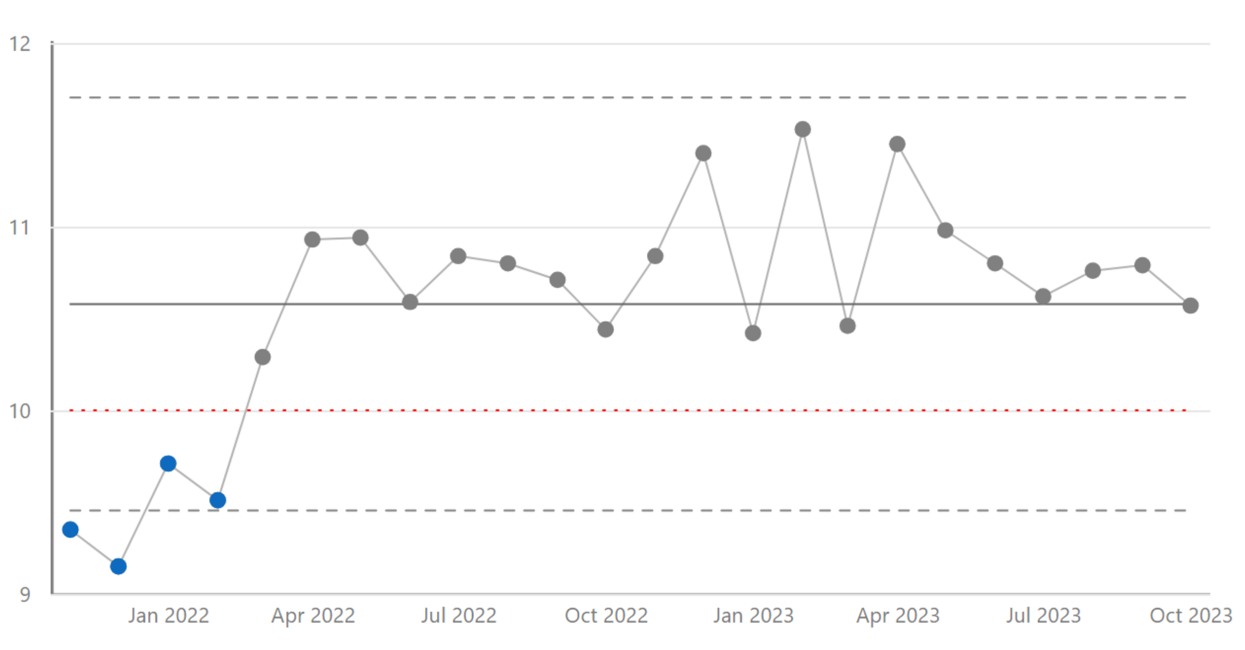
The standard for this indicator is within the upper and lower control limits

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	9.6%	10.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	11.3%	10.0%	Normal Variation	Achieve at Random
North Locality Care Group	9.1%	10.0%	Normal Variation	Achieve at Random
South Locality Care Group	9.0%	10.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Turnover decreased to 10.6% in October and was within the expected range of 9.4% and 11.7%.

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
- 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

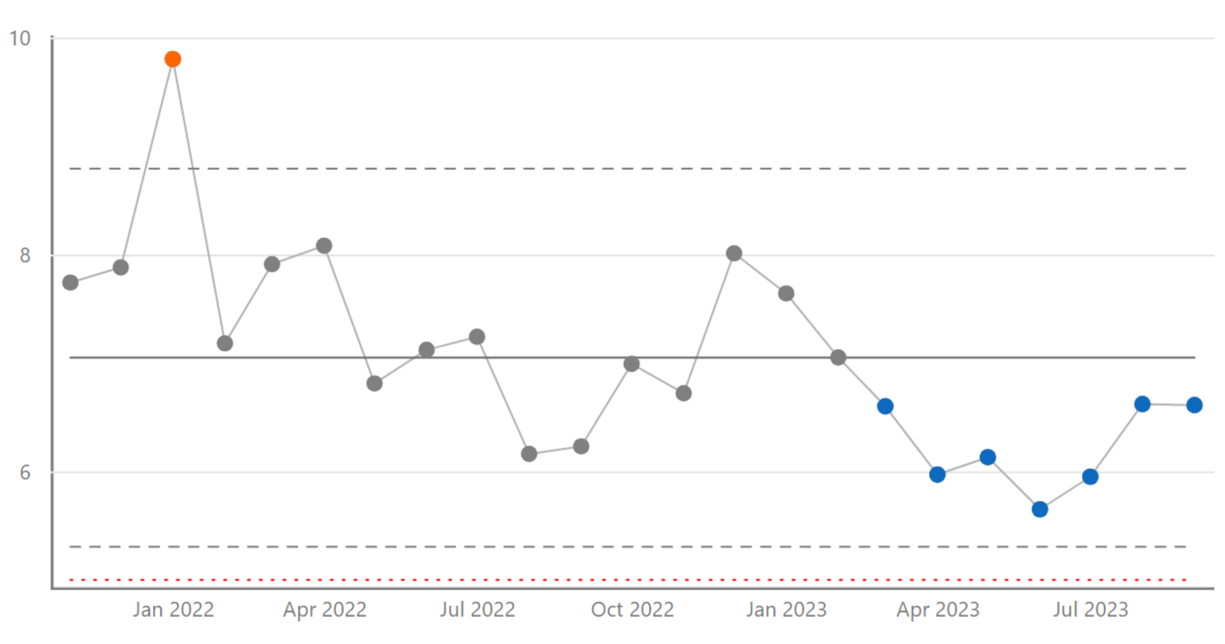
Risk Rating - **High (Action)**

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	6.6%	5.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	7.8%	5.0%	Normal Variation	Consistently Fail
North Locality Care Group	6.5%	5.0%	Improvement	Consistently Fail
South Locality Care Group	7.1%	5.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

Sickness of 6.6% in October was the seventh successive month in which it remained below the mean average of 7.1%, suggesting an underlying cause for the sustained decrease. The provisional sickness for October 2023 is reported at 6.85% remaining above the 5% standard

Root cause of the performance issue

- High mental health related absence
- High MSK absence
- COVID related absence

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.
    - SPC (Staff Psychological Centre)
    - Promotion of wellbeing conversations, stress risk assessments, carers passports and WRAP plans
- Introduction of ESR Supervisor Self Service (Limited Access)
- Review of Occupational Health DNA appointments
- Promotion of vaccine clinics for flu and COVID-19
- Secured funding for Bereavement post within SPC service.

Expected impact and by when

- Increased management overview, first point of contact/recording of sickness.
- Keeping staff feeling well at work
- Robust people management processes; including LTS and 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

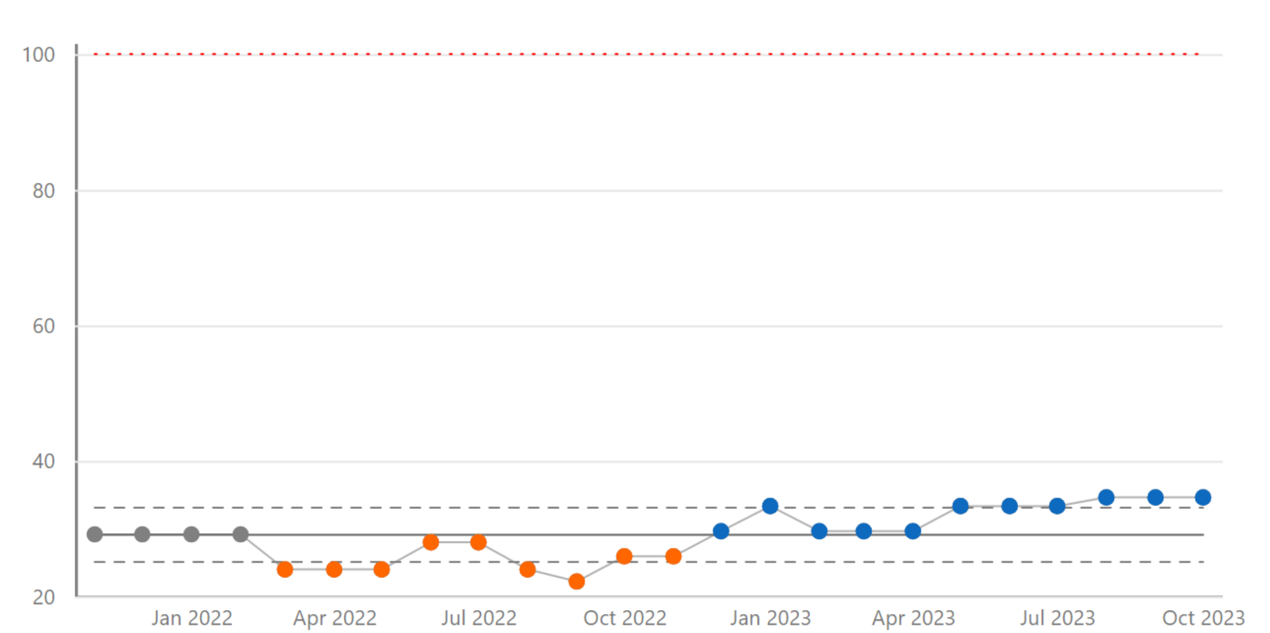
The standard for this indicator is outside the control limits

Improvement

This indicator is increasing which shows improvement

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	44.0%	100.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	30.8%	100.0%	Improvement	Consistently Fail
North Locality Care Group	48.0%	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 October which is slightly above the expected range of 25% to 33%. It is the eleventh successive month where performance was above the mean average. In October, 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 and to deliver training (PMVA)
- Late cancellations due to clinical activity
- Attachment of competencies to staff records - errors identified
- Volume of mandatory training requirements

Improvement Actions

- Prioritisation of Training Trajectories for PMVA at 85% by Q4 23/24 for all LD, Autism, CYPS, Adult Acute and Secure Wards now agreed. This is to ensure the high-risk areas for violence and aggression are prioritised to support patient and staff safety and reduce harm.
- 24/25 trajectories being prioritised into mandatory, essential and desirable. This will also include prioritising certain teams and job roles.
- The TNA tool with the modality of the training used to support planning of training trajectories and promotion of the modes of accessing training
- Train the trainer for some core programmes to deliver in place, bespoke training undertaken.

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: Oct 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	71.5%	85.0%	2057	2878	Internal	High (Action)
T02	Training - Clinical Supervision	Concern	Consistently Fail	76.3%	85.0%	2605	3415	Internal	High (Action)
T03	Training - Equality & Diversity Introduction	Improvement	Consistently Achieve	95.0%	85.0%	9567	10070	Internal	Low (On Track)
T04	Training - Fire	Improvement	Achieve at Random	87.1%	85.0%	8770	10070	Internal	Low (On Track)
T05	Training - Health & Safety	Improvement	Consistently Achieve	93.9%	85.0%	9455	10070	Internal	Low (On Track)
T06	Training - IPC	Improvement	Consistently Achieve	93.1%	85.0%	9377	10070	Internal	Low (On Track)
T07	Training - Medicines Management Training	Concern	Consistently Fail	61.2%	85.0%	1762	2878	Internal	High (Action)
T08	Training - Moving & Handling Awareness Training	Improvement	Consistently Achieve	94.0%	85.0%	9466	10070	Internal	Low (On Track)
T09	Training - PMVA Basic	Improvement	Consistently Fail	56.7%	85.0%	1433	2528	Internal	High (Action)
T10	Training - Rapid Tranquilisation Training	Concern	Consistently Fail	62.0%	85.0%	896	1446	Internal	High (Action)
T11	Training - Safeguarding Adults Level 1	Improvement	Consistently Achieve	95.4%	85.0%	2393	2508	Internal	Low (On Track)
T12	Training - Safeguarding Adults Level 2	Improvement	Achieve at Random	91.7%	85.0%	2614	2851	Internal	Low (On Track)
T13	Training - Safeguarding Adults Level 3	Improvement	Consistently Fail	78.8%	85.0%	3471	4407	Internal	High (Action)
T14	Training - Safeguarding Children Level 1	Improvement	Consistently Achieve	95.6%	85.0%	2397	2508	Internal	Low (On Track)
T15	Training - Safeguarding Children Level 2	Improvement	Consistently Fail	88.9%	85.0%	2533	2851	Internal	Med (Monitoring)
T16	Training - Safeguarding Children Level 3	Improvement	Consistently Fail	81.6%	85.0%	3594	4407	Internal	Med (Monitoring)
T17	Training - Information Governance	Improvement	Consistently Fail	91.9%	95.0%	9256	10070	Internal	Med (Monitoring)
T18	Training - Seclusion Training	Concern	Consistently Fail	51.4%	85.0%	1620	3152	Internal	High (Action)
T19	Training - PMVA Breakaway	Concern	Consistently Fail	64.0%	85.0%	2415	3773	Internal	High (Action)
T20	Training - MHA MCA DoLS Combined	Normal Variation	Consistently Fail	60.9%	85.0%	3786	6222	Internal	High (Action)
T21	Training Resuscitation L2 Adult Basic Life Support	Normal Variation	Consistently Fail	55.1%	85.0%	991	1799	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	27.8%	85.0%	219	789	Internal	High (Action)
T24	Training Resuscitation L3 Adult Immediate Life Supp	Improvement	Consistently Fail	55.9%	85.0%	1761	3151	Internal	High (Action)
T25	Training Resuscitation L3 Paediatric Immed Life Supp	Normal Variation	Consistently Fail	0.0%	85.0%	0	267	Internal	High (Action)
T26	Training - Autism Core Capabilities: Tier 1 & 2	SPC N/A		55.7%	85.0%	530	952	Internal	High (Action)
T27	Training - Learning Disability Tier 1	SPC N/A		55.3%	85.0%	526	952	Internal	High (Action)

P04 - Appraisal rate

Appraisal rate

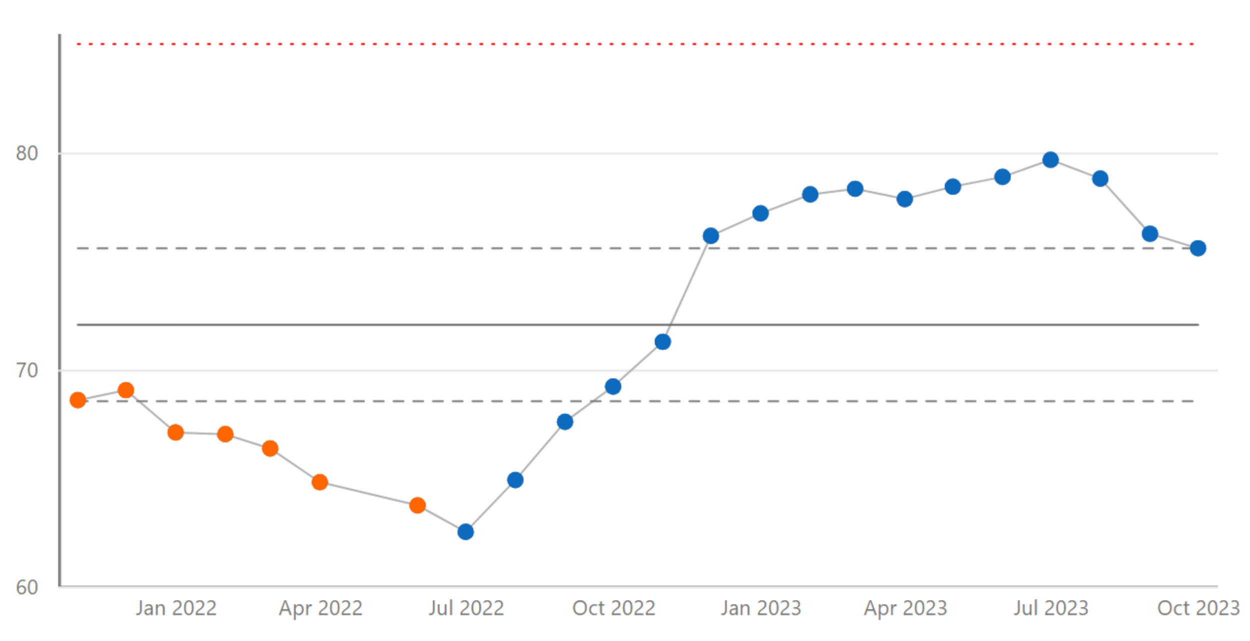
Risk Rating - **High (Action)**

Performance - 75.6%
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	74.5%	85.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	72.1%	85.0%	Improvement	Consistently Fail
North Locality Care Group	74.3%	85.0%	Improvement	Consistently Fail
South Locality Care Group	80.0%	85.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

The appraisal rate was 75.6% in October, the eleventh consecutive month higher than the mean average. The standard will not be met unless something changes

Root cause of the performance issue

- Capacity to prepare and undertake appraisal – staffing pressures
- 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

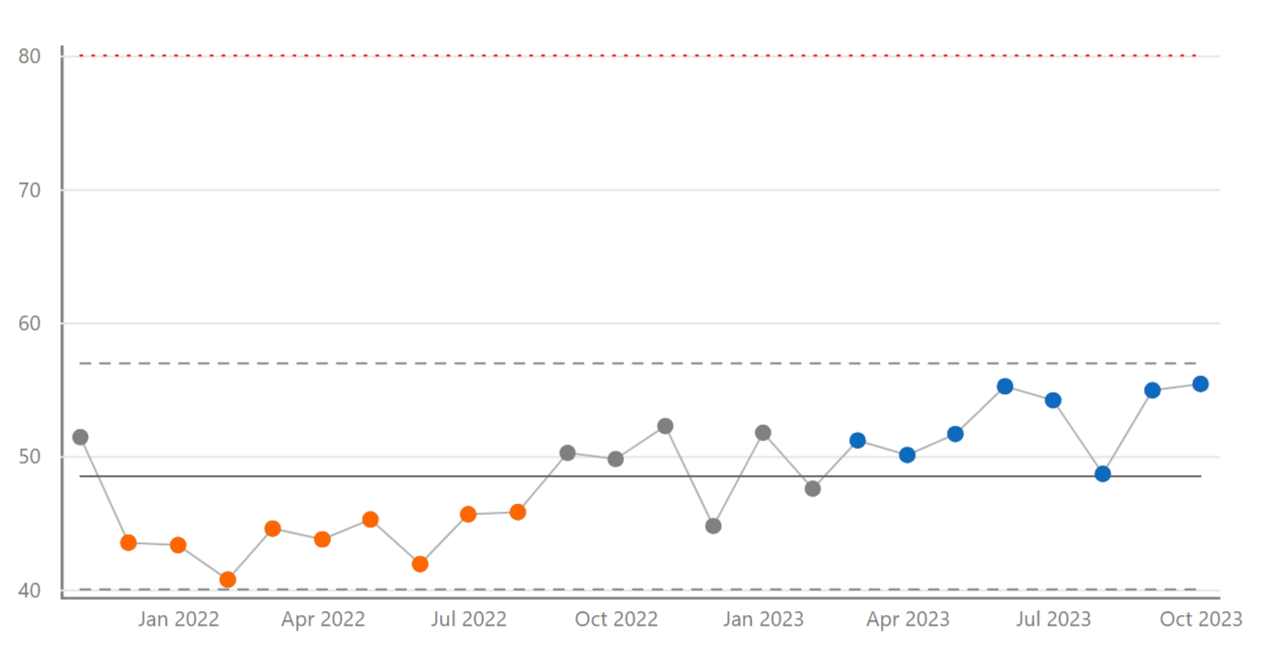
Risk Rating - **High (Action)**

Performance - 55.4%
Standard - 80.0%

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	54.7%	80.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	46.7%	80.0%	Normal Variation	Consistently Fail
North Locality Care Group	58.2%	80.0%	Improvement	Consistently Fail
South Locality Care Group	63.1%	80.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Performance of 55.4% in October was consistent with the expected range of 40% to 57%. The standard will not be met without significant change.

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 Clinical Management CMT) and Quality Standards and Oversight (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
- Working with line managers to develop plans to ensure utilising all registered staff to support supervision of non-registered staff

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

Q02 - Serious Incidents

Risk Rating - **High (Action)**

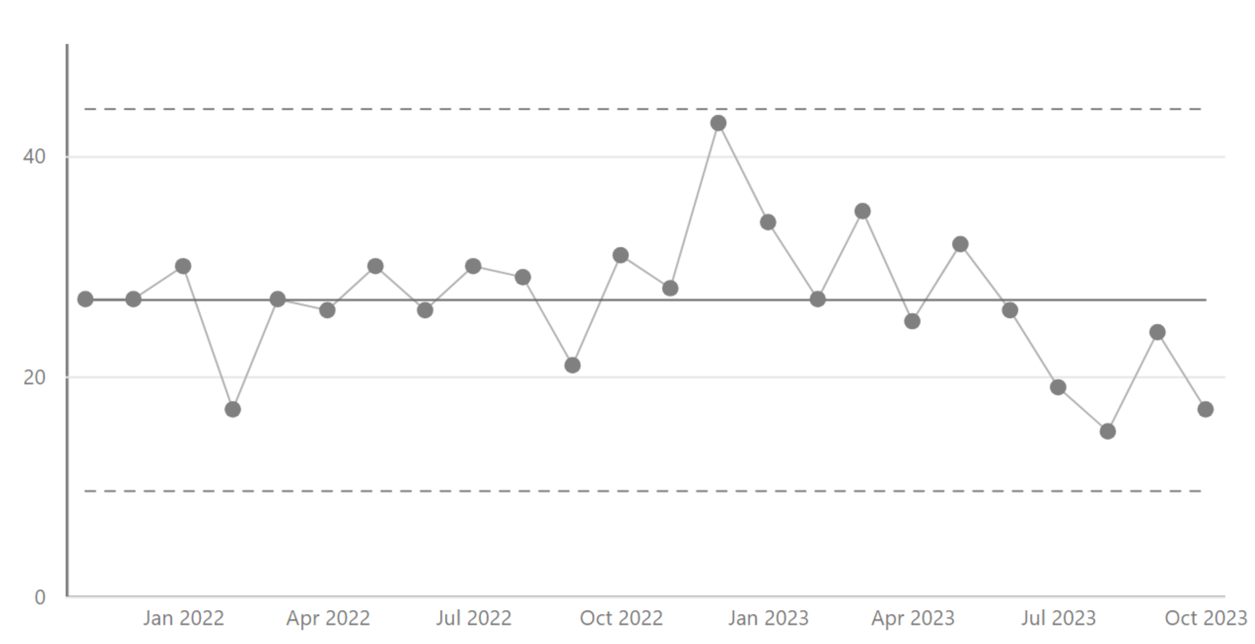
Number of Serious Incidents

Performance - 17
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	5	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	5	No Std	Normal Variation	No Standard
North Locality Care Group	5	No Std	Improvement	No Standard
South Locality Care Group	2	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

17 serious incidents were recorded within October. 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. October's figures are below the monthly average and a decrease 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. Learning is shared through various forums including locality safety and quality meetings, learning lessons groups, Trust and Safer Care bulletins.

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.

Q06 - Aggression and Violence

Aggression and Violence

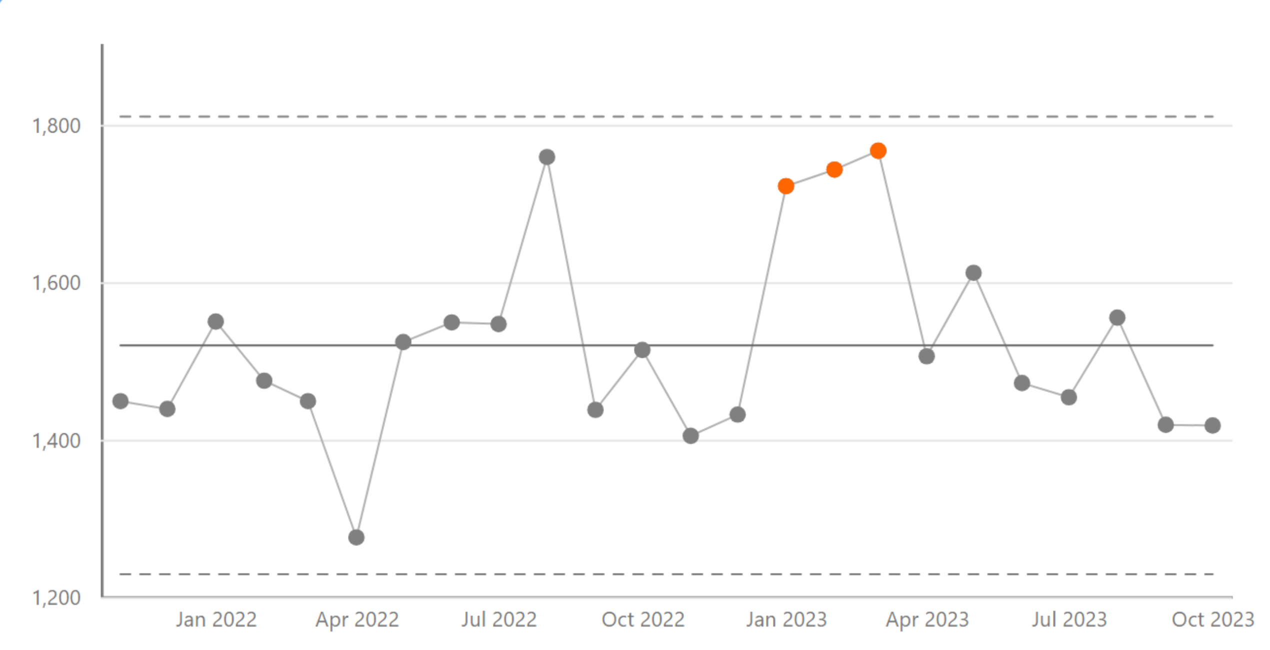
Risk Rating - **Med (Monitoring)**

Performance - 1,418
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	257	No Std	Improvement	No Standard
North Cumbria Locality Care Group	328	No Std	Normal Variation	No Standard
North Locality Care Group	459	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 1,418 recorded incidents of aggression and violence during October which falls within the calculated expected range of 1,229 and 1,810 incidents. Unusually this is within 1 incident of the previous months figure of 1,419.

Root Cause of the performance issue

October activity for aggression and violence is lower than the same period last year and has seen a reduction of 6.34% over the same period at the same time as incident reporting for this financial year has risen by 2.29%. 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, and these areas will be the focus of the Health and Safety Executives inspection in February 2024 when they commence their 2 day inspection regime focussing on aggression and violence and our monitoring , review and improvements, with a significant focus on the training for the workforce.

Improvement Actions

Talk 1st dashboard is now being used , by a number of clinical and operational staff to review activity and formed the basis of last month's update for reducing restrictive intervention session for board, which shows integration to our approach. This dashboard has been accessed over 2,000 times in the last 3 months to support patient assessment, risk planning and learning.

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

Risk Rating - **Med (Monitoring)**

Care Plans compliance

Performance - 94.4%

Standard - 95.0%

Consistently Fail

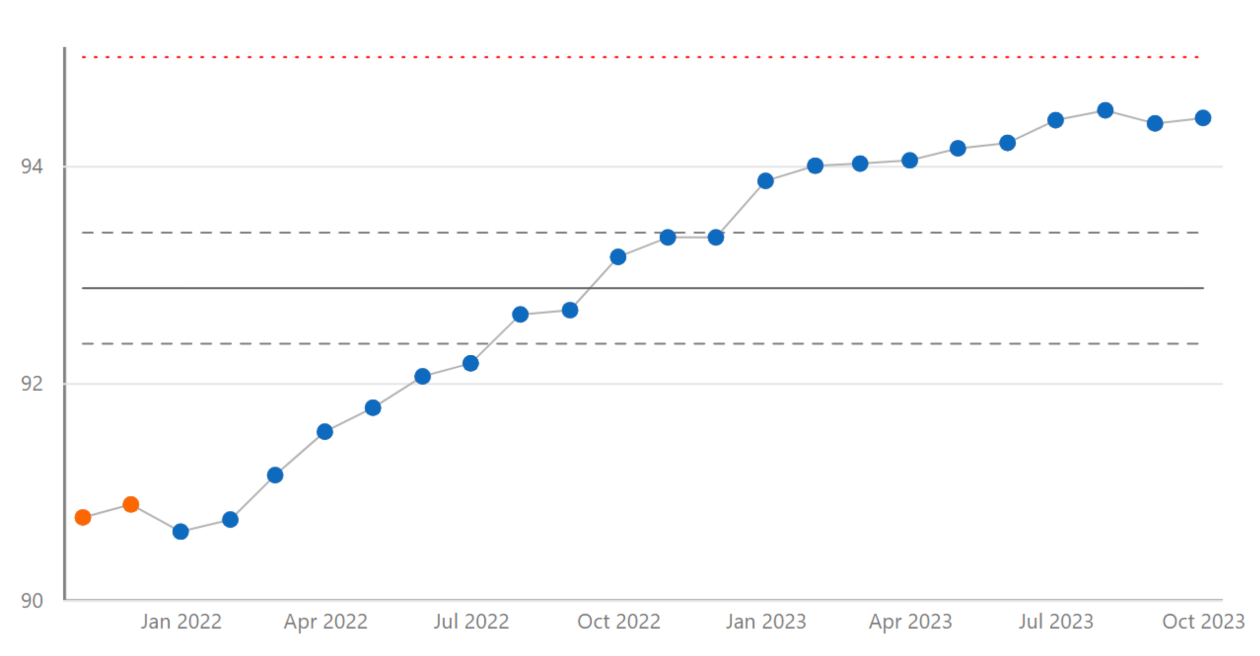
The standard for this indicator is outside the control limits

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	96.0%	95.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	87.3%	95.0%	Improvement	Consistently Fail
North Locality Care Group	96.3%	95.0%	Improvement	Consistently Achieve
South Locality Care Group	94.0%	95.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

Performance of 94.4% in October remained below the standard of 95%.

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.

Monthly case load supervision to support compliance.

Expected impact and by when

This metric is profiled by small incremental improvement, with only one month reporting a dip in the past 12 months, we are on trajectory to reach the target with only a 0.6% improvement required to reach 95%.

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 - 88.9%

Standard - 95.0%

Consistently Fail

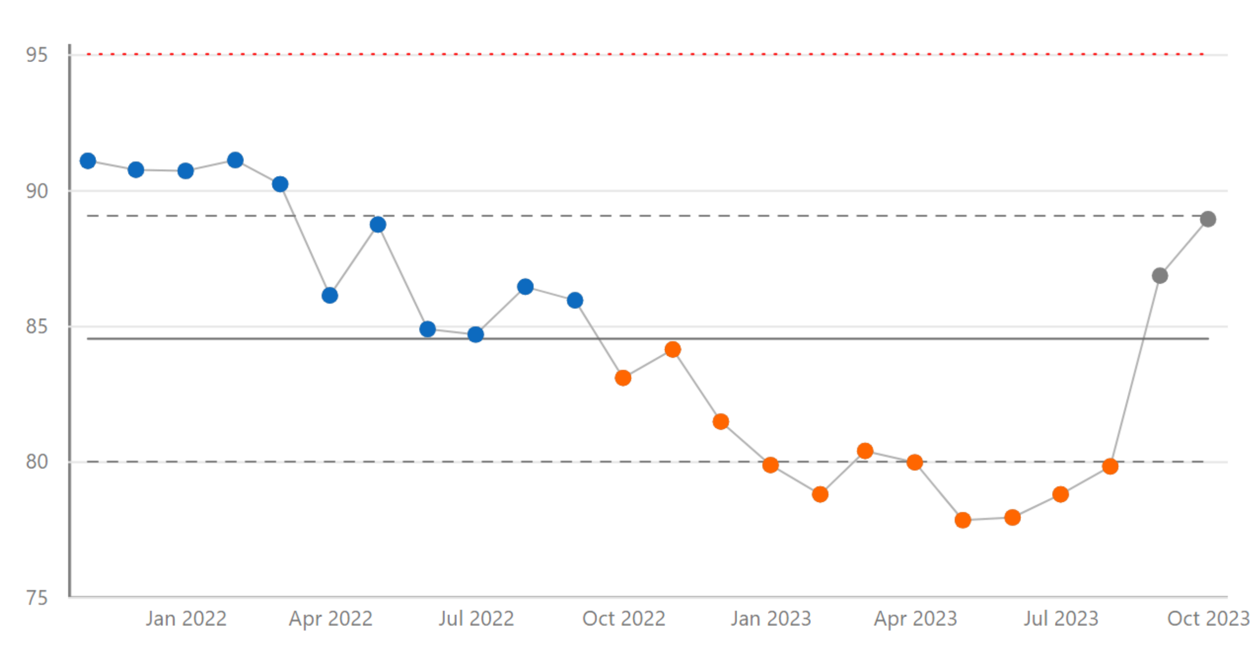
The standard for this indicator is outside the control limits

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	95.9%	95.0%	Improvement	Achieve at Random
North Cumbria Locality Care Group	65.7%	95.0%	Normal Variation	Consistently Fail
North Locality Care Group	98.1%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	92.0%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

CPA completed reviews 88.9% for October, though it remained below the 95% standard. The expected range of compliance is between 80% to 89%.

Root Cause of the performance issue

CPA review metric has improved for the third consecutive month within the South Locality. There has been an area of focus for improvement

Central Locality has achieved the standard this month for the first time since March 2022 following a sharp rise in compliance over the last 4 months.

Improvement Actions

Monthly case management supervision with a focus on completion of CPA documentation, and early identification of any individual performance concerns.

Central Community CBU made some changes in the way CPA reviews are booked with medics which has helped to improve compliance.

Continued 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 has been achieved in both Central and North locality this month and a positive improvement within South. Work continues across localities.

Q11 - Staffing fill rates

Risk Rating - **High (Action)**

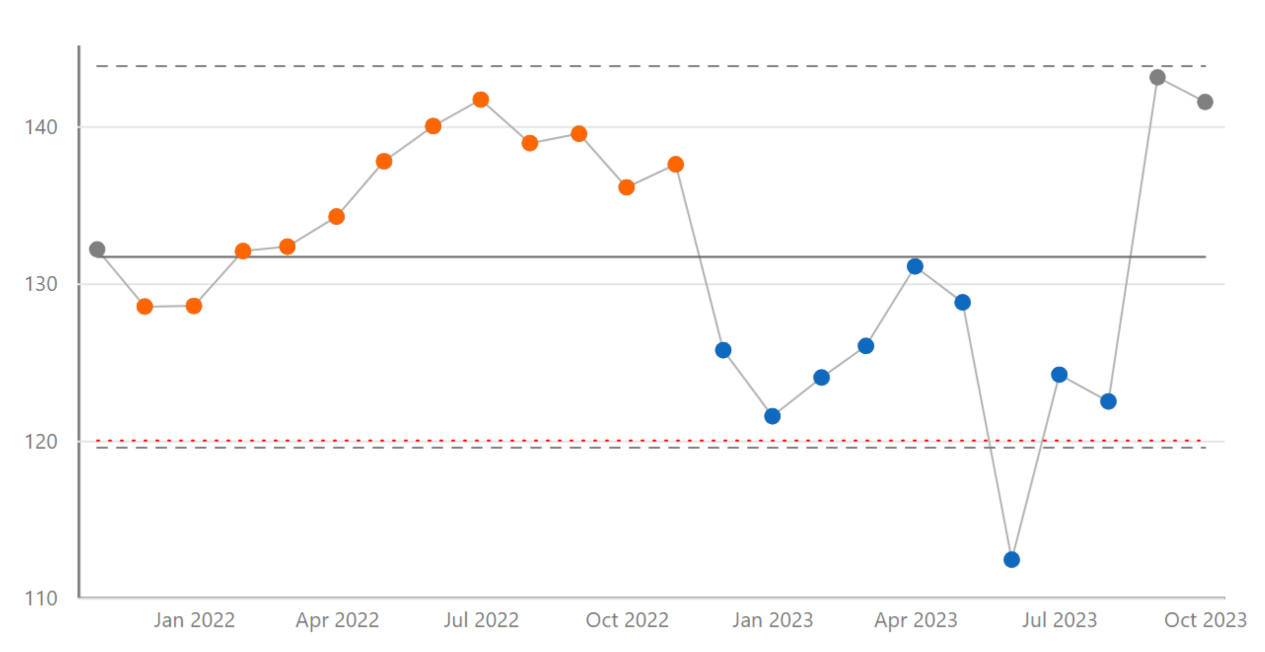
Staffing fill rates - All day/night and Reg/Unreg

Performance - 141.5%
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 - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	163.9%	120.0%	Concern	Consistently Fail
North Cumbria Locality Care Group	148.6%	120.0%	Concern	Achieve at Random
North Locality Care Group	123.1%	120.0%	Normal Variation	Achieve at Random
South Locality Care Group	134.5%	120.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Staffing fill rate was 141.5% in October 2023.

Root Cause of the performance issue

There remain vacancies across inpatient services.

Localities are consistently failing to have staffing fill rates less than 120% affecting the overall performance of this measure.

Reporting is 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.

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

Risk Rating - **High (Action)**

Out of Area Placement bed days

Performance - 39
Standard - 155

Achieve at Random

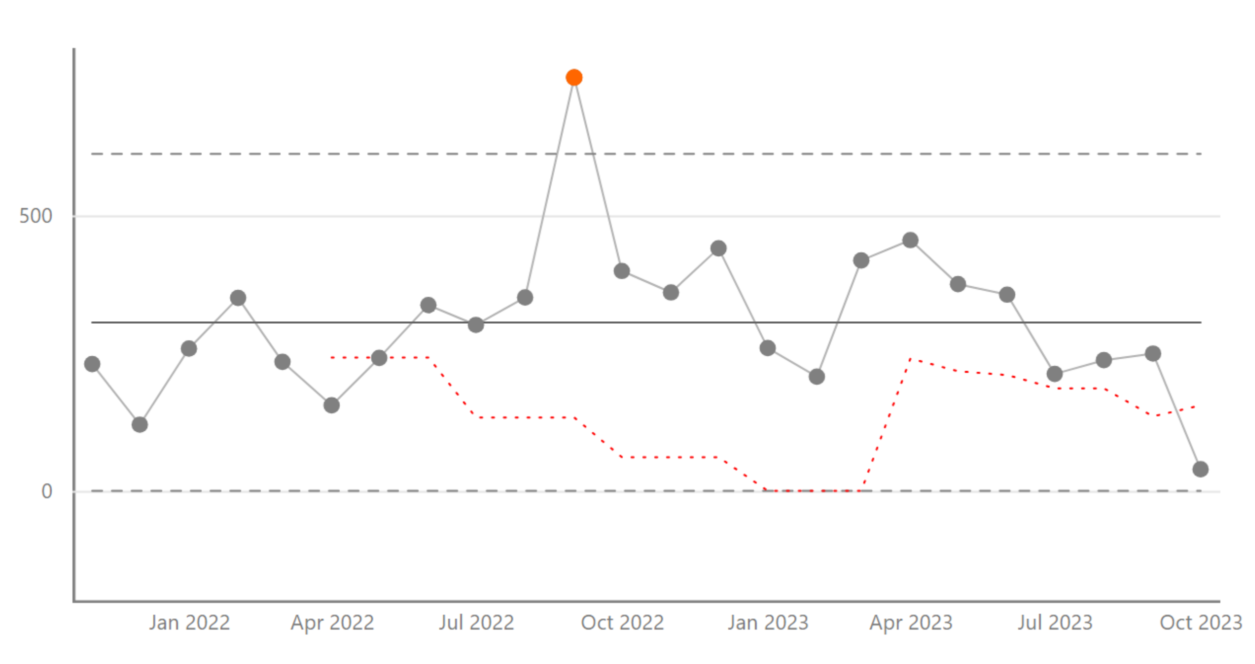
The standard for this indicator is within the upper and lower control limits

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	26	No Std		No Standard
North Cumbria Locality Care Group	0	No Std		No Standard
North Locality Care Group	0	No Std		No Standard
South Locality Care Group	13	No Std		No Standard

Feedback

What the chart tells us

There were a total of 39 Out of Area Placement bed days reported in October relating to 7 patients all within the adult acute pathway. The locality breakdown is based on the patients' home address.

Root Cause of the performance issue

Service users requiring inpatient admission where there are no appropriate CNTW bed available, or there is a clinical rationale for out of area pertaining to specific service user circumstances. There has been significant reduction in bed days.

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

Improvement Actions

EBM continue to follow recently implemented process. There is an identified Bed Manager for each locality with a focus on Out of Area placements. They take a pro-active approach to support re-patriation where clinically appropriate and in the best interest of the service user. This process is managed via weekly EBM meetings including Team Manager and Clinical Manager, and improvement has been noted since implementation.

Expected impact and by when

Ambition is for zero OOA placements by 31st March 2024, this may vary upon clinical needs and requirements. Potential to see an increase during winter pressures, though the current robust process should sustain lower OOA than previously recorded.

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

Risk Rating - **High (Action)**

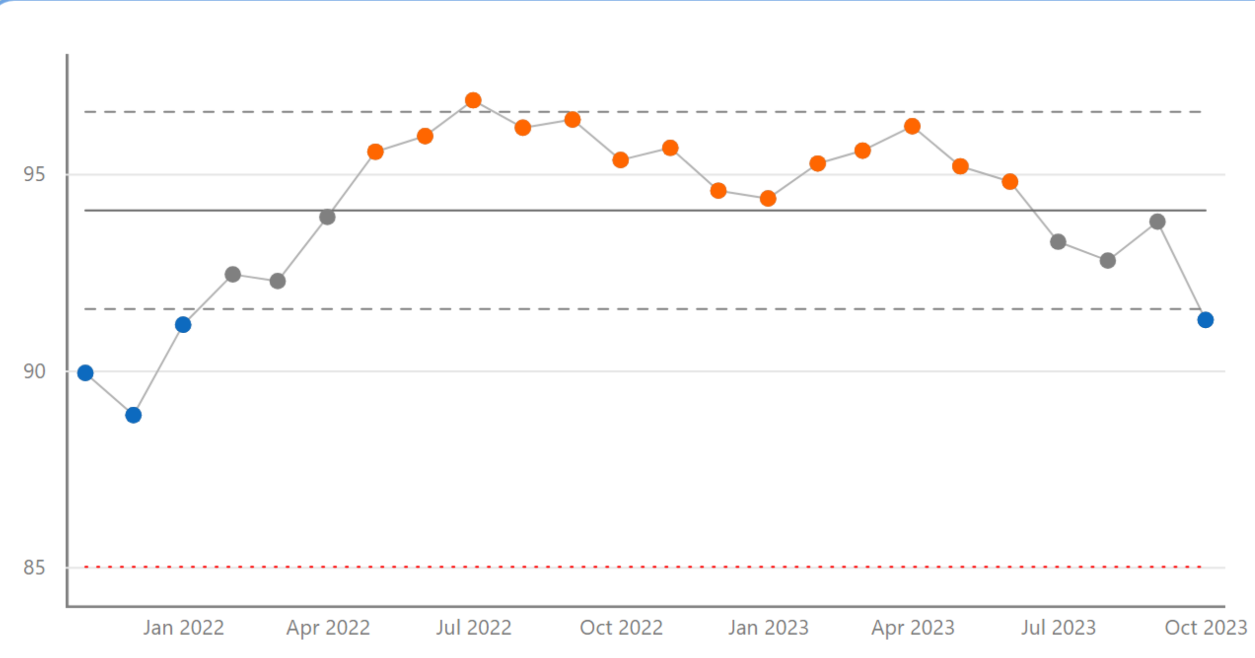
Bed Occupancy including leave (open beds on RiO)

Performance - 91.3%
Standard - 85.0%

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	91.0%	85.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	83.3%	85.0%	Normal Variation	Achieve at Random
North Locality Care Group	94.7%	85.0%	Improvement	Consistently Fail
South Locality Care Group	92.6%	85.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Bed occupancy was at 91.3% which showed improvement in October, this is below the expected range of 91.6% to 96.6%. However, this is higher than the optimal level of 85%.

Root Cause of the performance issue

Bed availability in line with national performance and pressures.

Improvement Actions

EBM discharge facilitators support wards and are attached to each locality for consistency.

Implementation of admission and discharge policy.

System wide working with third sector. Homegroup remains in the South locality

Expected impact and by when

It is predicted that over the winter period bed occupancy will remain above the optimal level of 85% but the actions above will maintain 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 - 11.4%

Standard - 7.5%

Consistently Fail

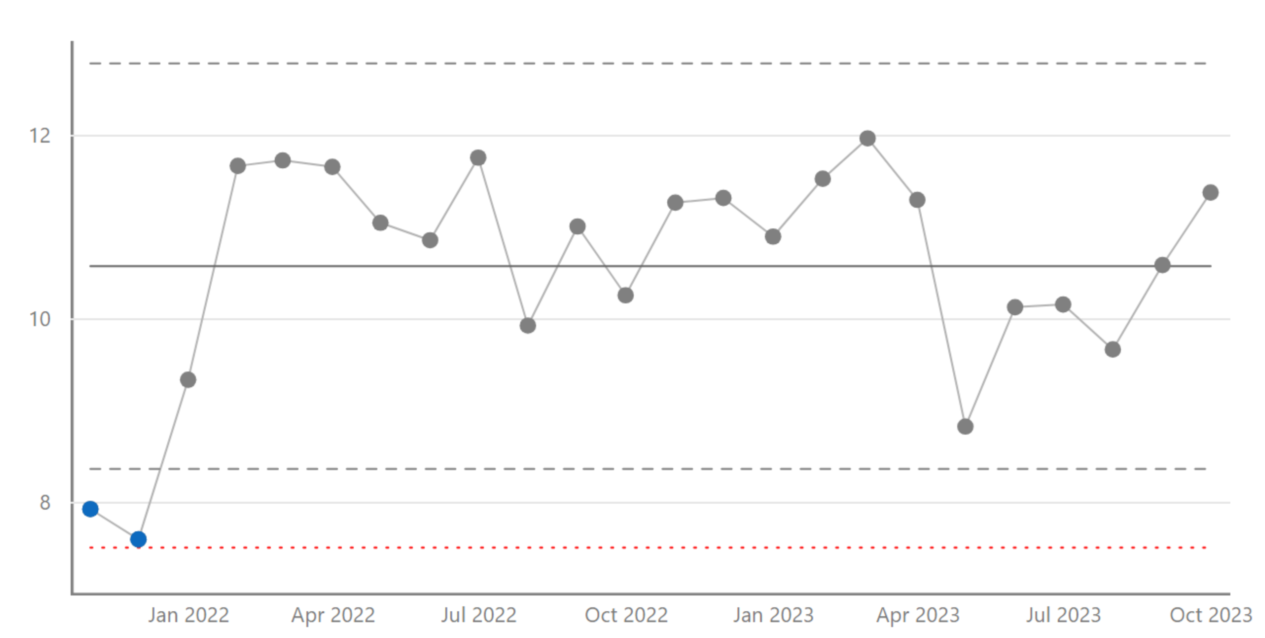
The standard for this indicator is outside the control limits

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	6.4%	7.5%	Concern	Consistently Achieve
North Cumbria Locality Care Group	27.6%	7.5%	Normal Variation	Consistently Fail
North Locality Care Group	12.9%	7.5%	Normal Variation	Consistently Fail
South Locality Care Group	9.3%	7.5%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In October 11.4% of patients were clinically ready for discharge, which is within the expected range of 8. 4% to 12.8%.

Root Cause of the performance issue

System wide challenges with complex discharges and lack of appropriate support and care packages.

Improvement Actions

Red and Green Days implemented across acute wards.

Fortnightly CRFD meetings with Local Authority and Place based ICB.

Expected impact and by when

It is anticipated that over the winter period CRFD will remain above the optimal level of 7.5% but the actions above will support and 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 - 46.7%

Standard - No Std

No Standard

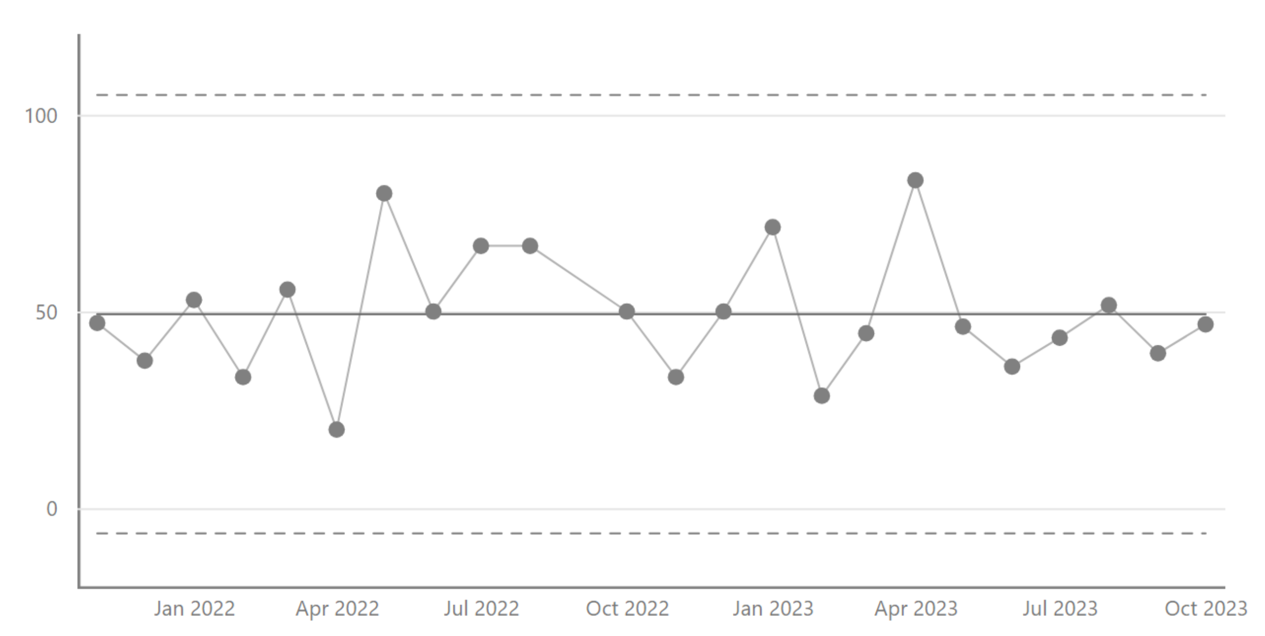
Assurance cannot be given for this indicator as there is no standard set

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	44.6%	No Std		No Standard
North Cumbria Locality Care Group	50.0%	No Std		No Standard
North Locality Care Group	33.3%	No Std	Normal Variation	No Standard
South Locality Care Group	100.0%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Very urgent referrals seen within 4 hours increased to 46.7% in October

Root Cause of the performance issue

- Low referrals numbers within all localities with the exception of Central where a significant increase in the number or referrals recorded as very urgent has been seen within the month although overall % has not been impacted. The increase coincides with the reintroduction of the AOG subgroup looking at categorising the urgency of referrals.
- Data quality relating to incorrect categorisation of referral urgency between teams
- Staffing pressures within the WAA pathway has been a pressure this financial year in the North (5.2xB6 vacancies).

Improvement Actions

- Review of each very urgent breach takes place within the North to support assurance and learning.
- Reviewing MDT process and HBT review process in order to ensure caseload pressures are managed effectively (North).
- Trust-wide work taking place around HBT in terms of flow and efficiency.
- Access oversight group re-introduced and meeting monthly with a focus on Very Urgent and Urgent recording and criteria.
- Weekly reporting, with actions plans being discussed in wider Community Oversight Group.

Expected impact and by when

Timeframes 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 - 82.1%

Standard - No Std

No Standard

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

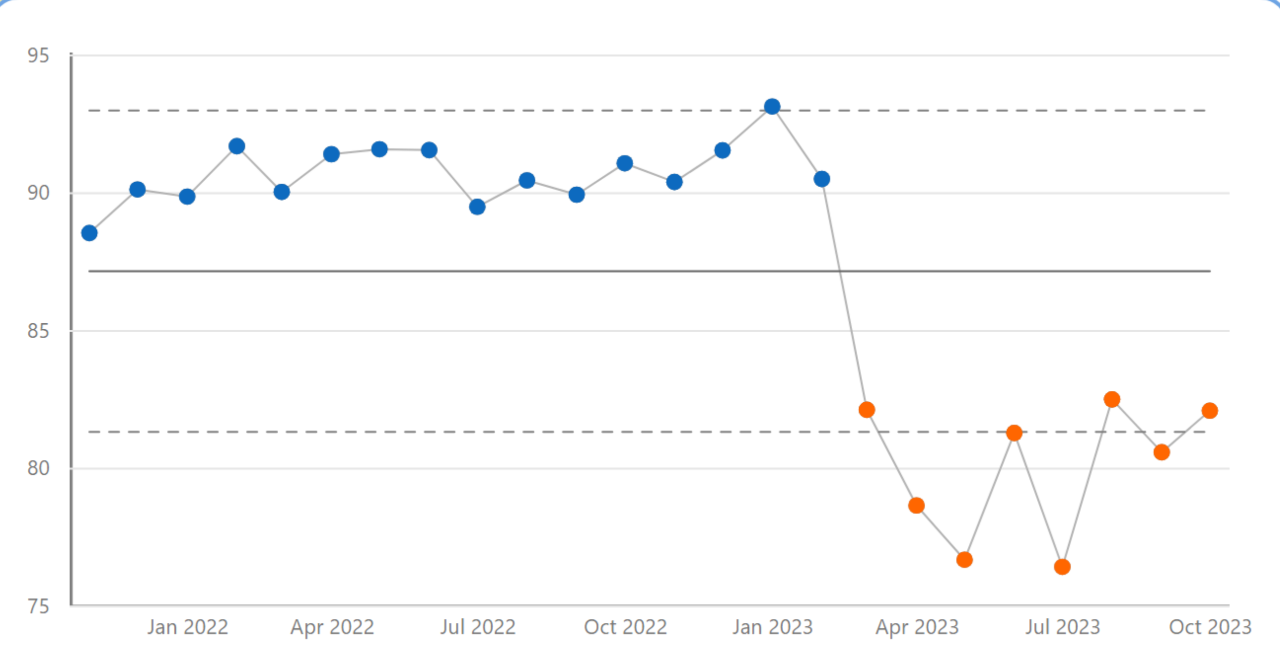
Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator

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



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	83.9%	No Std	Concern	No Standard
North Cumbria Locality Care Group	81.4%	No Std	Concern	No Standard
North Locality Care Group	69.8%	No Std	Normal Variation	No Standard
South Locality Care Group	91.6%	No Std	Improvement	No Standard

Feedback

What the chart tells us

Urgent referrals seen within 24 hours increased to 82.1% in October, the 8th consecutive month showing concern suggesting there has been an underlying change.

Root Cause of the performance issue

- Staffing pressures within the WAA pathway has been a pressure this financial year in the North (5.2xB6 vacancies).
- A high number of referrals are discharged unseen (especially in the WAA pathway) – these breaches are impacting compliance.
- Data quality relating to incorrect categorisation of referral urgency between teams
- 136 model and impact on compliance.

Improvement Actions

- Reviewing MDT process and HBT review process in order to ensure caseload pressures are managed effectively (North).
- Trust-wide work taking place around HBT in terms of flow and efficiency.
- Review of patients discharge unseen – narrative / scenarios are being fed into the Access Oversight Group guidance review to agree standardised ways of recording.

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 - 63.5%

Standard - No Std

No Standard

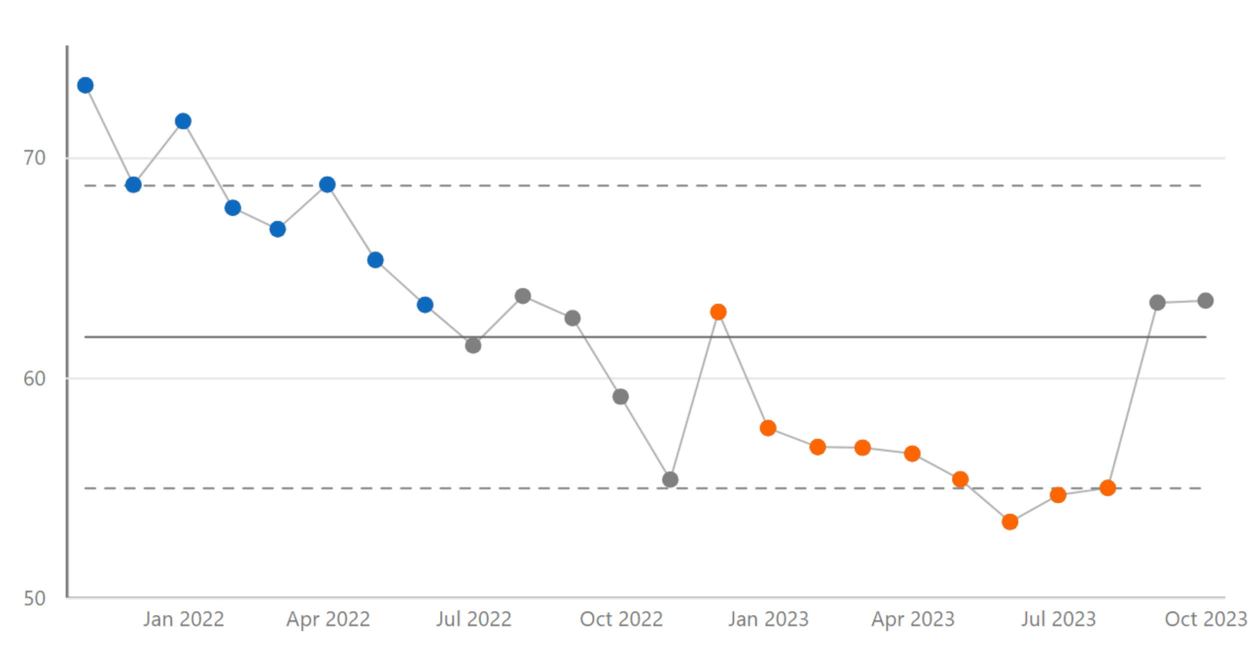
Assurance cannot be given for this indicator as there is no standard set

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	55.8%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	64.5%	No Std	Normal Variation	No Standard
North Locality Care Group	54.1%	No Std	Normal Variation	No Standard
South Locality Care Group	83.2%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Performance was 63.5% in October which is within the expected range between 55% and 68.7%.

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.
- Staffing (recruitment/retention/sickness) remains a challenge.
- North Locality cover 9 hospital sites across Northumberland and North Tyneside (potential travel from Berwick Infirmary to North Tyneside General Hospital).
- Newcastle PLT is not resourced sufficiently for the size of the hospitals covered.

Improvement Actions

- Access Oversight undertaking a mapping exercise to understand the recording practices in each Locality to inform decision making regarding standardised approach.
- Central locality fortnightly meetings in place with CBU leadership and action plan developed including establishing shift coordinator role, improving recording practices in the team, developing guidance for ED staff regarding when to refer to PLT and development of business case to share with commissioners.
- Specific to North locality:

Recommendations from the recent senior clinical PLT review being implemented, these include:

- Progressing with the implementation of digital dictation and efficient ways of accessing the acute trusts patient electronic record system
- Establishment of a shift coordinator role commencing in October 2023
- Discussions taking place with NSECH regarding referrals to PLT

Expected impact and by when

Data quality work, alongside proactive recruitment remains ongoing with 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 - 23.8%

Standard - No Std

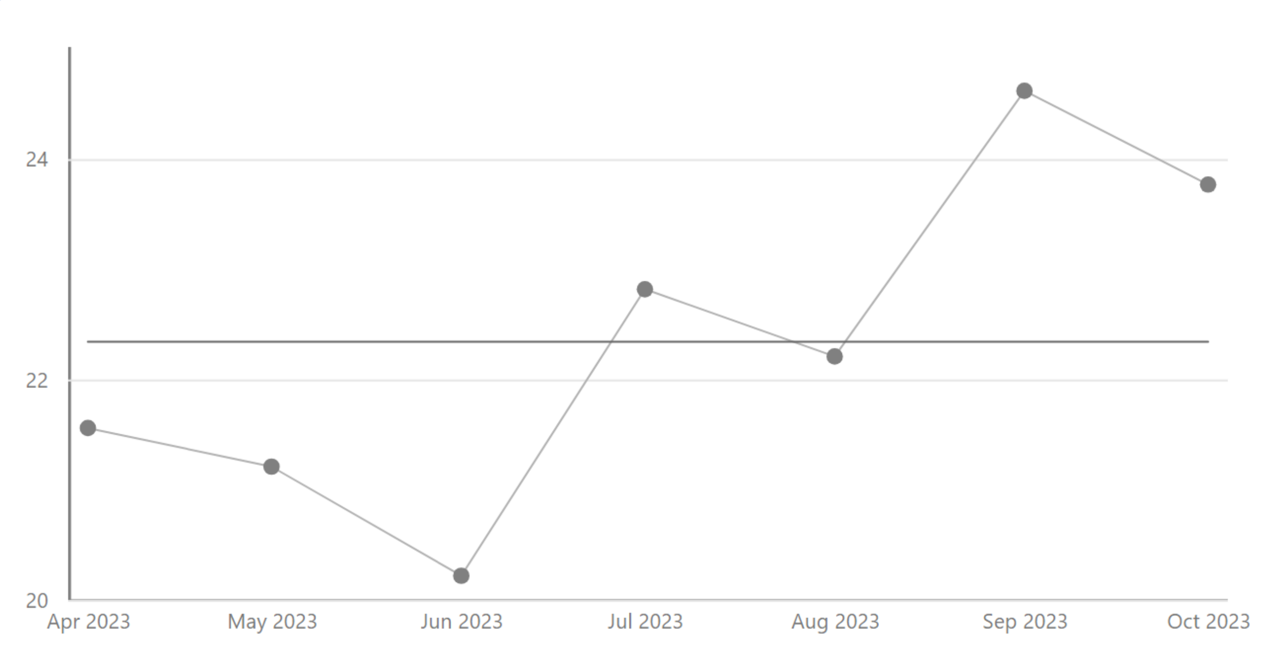
No Standard

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

Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	33.5%	No Std		No Standard
North Cumbria Locality Care Group	7.9%	No Std		No Standard
North Locality Care Group	42.7%	No Std		No Standard
South Locality Care Group	20.3%	No Std		No Standard

Feedback

What the chart tells us

In October 23.8% of referrals are reported to have been waiting 4 weeks or less to treatment.

Root Cause of the performance issue

This is a new metric introduced in July, as such there is a significant amount of work underway to embed new processes alongside data quality work to ensure the position is accurately reflecting operational delivery.

Improvement Actions

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

Training sessions continue to be advertised and staff are attending these

Review of issues and options appraisal for referrals into CTTs that will not meet 4 week wait standards e.g. referrals for medication initiation or PH monitoring.

Ongoing communication and embedding of the 4WW recording requirements and continue to use monthly Performance Clinics to review each Teams position. (North Locality saw an improvement of 5.9% from Sep to Oct).

Monthly feedback an update to oversight group.

Implementation of group work in the South Locality to support treatment pathways.

Expected impact and by when

This metric has oversight at the internal waiting times meeting. Each locality, has provided an action plan which is reviewed and questioned each month to provide assurance on delivery. The actions from the localities are detailed up to Q4.

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

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

Risk Rating - **High (Action)**

Performance - 12.6%
Standard - No Std

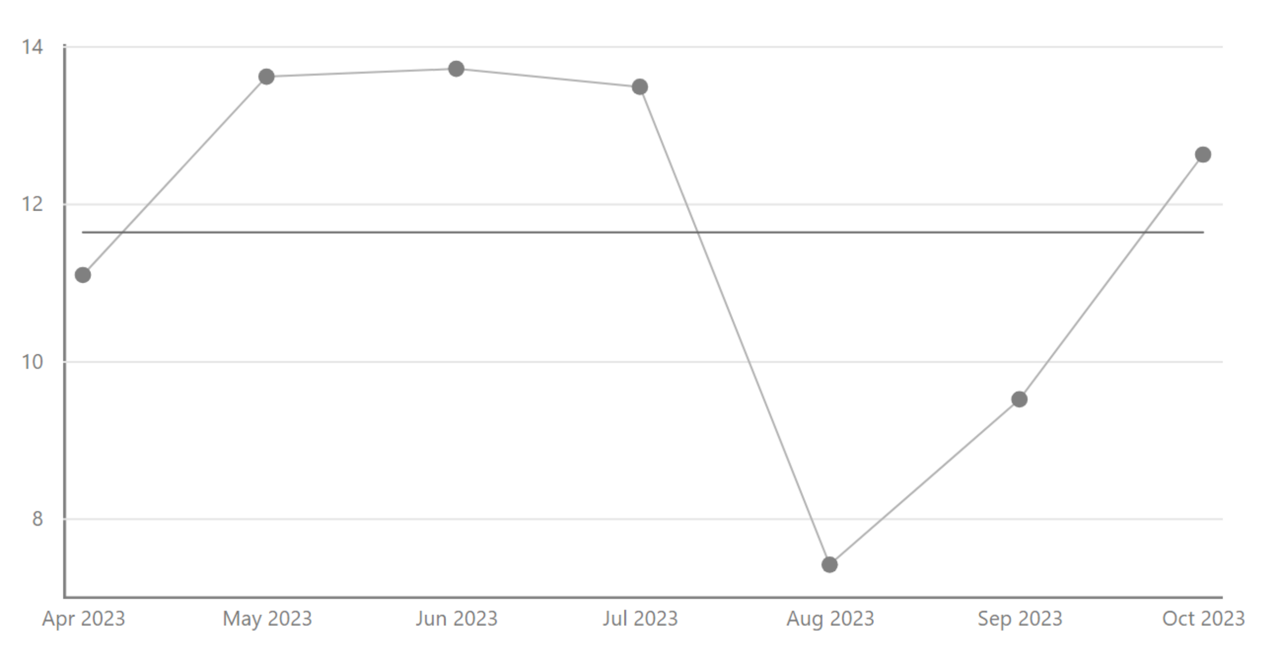
No Standard

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

Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	9.1%	No Std		No Standard
North Cumbria Locality Care Group	7.3%	No Std		No Standard
North Locality Care Group	67.5%	No Std		No Standard
South Locality Care Group	73.7%	No Std		No Standard

Feedback

What the chart tells us

In October 12.6% of referrals are reported to have been waiting 4 weeks or less to receive help.

Root Cause of the performance issue

Ability to undertake ADHD assessments and current demand and capacity issues.

Improvement Actions

Welcome Events in the neuro pathway continue to be in place and are being received positively by stakeholders.

Ongoing communication and embedding of the 4WW recording requirements and continue to use monthly Performance Clinic to review Team/ pathway position. (North Locality saw an improvement of 18.2% from Sep to Oct).

Using Performance Clinics to share new developments in dashboard which can support the monitoring of waiting time compliance.

Automated weekly unoutcomed appointment reporting in place and is currently being shared directly with Teams.

In Central Locality work is ongoing to support Getting Help partners to flow data to MHSDS and Getting Help partnership strengthening relationships with wider system partners to ensure young people are offered support from the most appropriate service at the earliest opportunity.

Expected impact and by when

Reduction in the number of CYPS waiting (excluding referrals within the Neuro pathway) 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 - 9.1%
Standard - No Std

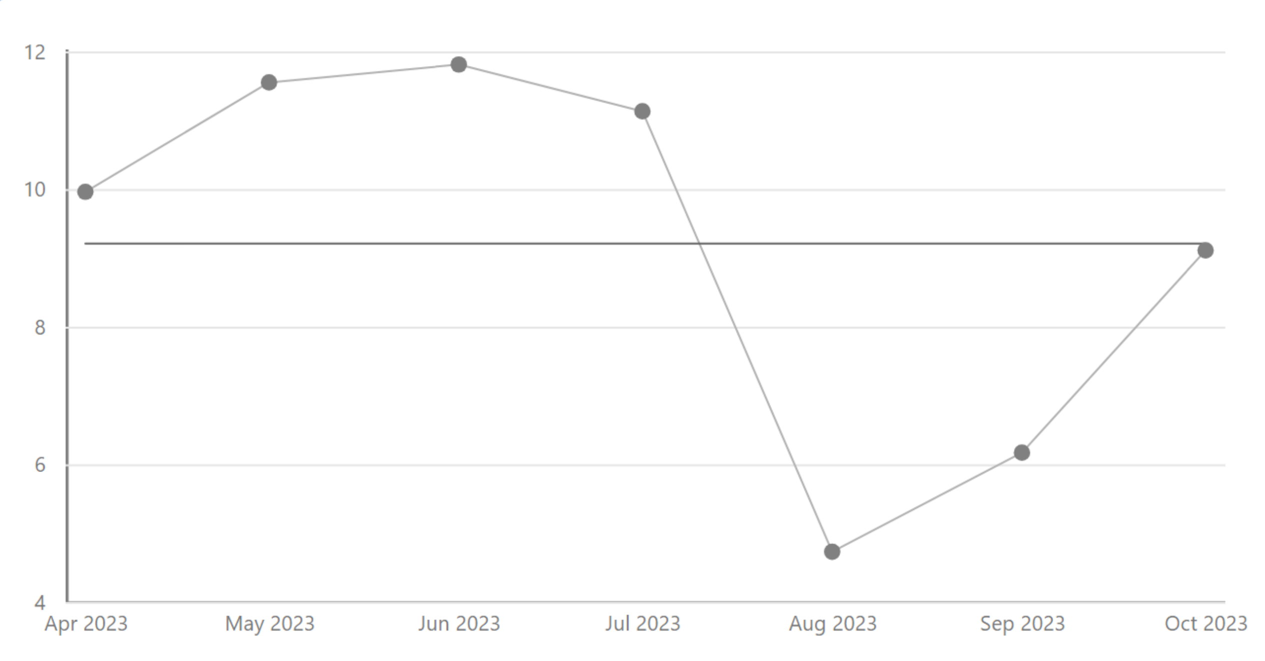
No Standard

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

Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6.0%	No Std		No Standard
North Cumbria Locality Care Group	6.2%	No Std		No Standard
North Locality Care Group	60.6%	No Std		No Standard
South Locality Care Group	71.7%	No Std		No Standard

Feedback

What the chart tells us

In October 9.1% 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

South Locality has focused work with local schools and multi-agency pre referral triage for appropriate signposting.

New Neuro-developmental pathway proposal was presented at the Community Oversight Group, the redesigned pathway requires further refinement by early November for presentation to BDG in December 23.

In the North Welcome Events in the neuro pathway continue to be in place. Service reviewing the frequency needed in each geographical area. Service have reviewed the frequency of waiting list management call expectations per pathway. A standard operating procedure (SOP) is in development and the Service will be working to embed this into practice.

Central Locality strengthening relationship with wider system partners to ensure young people are able to access support regardless of diagnosis.

Central locality neuro team manager due to start in Q3 to strengthen leadership in team.

Expected impact and by when

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 - 96.2%

Standard - 95.0%

Achieve at Random

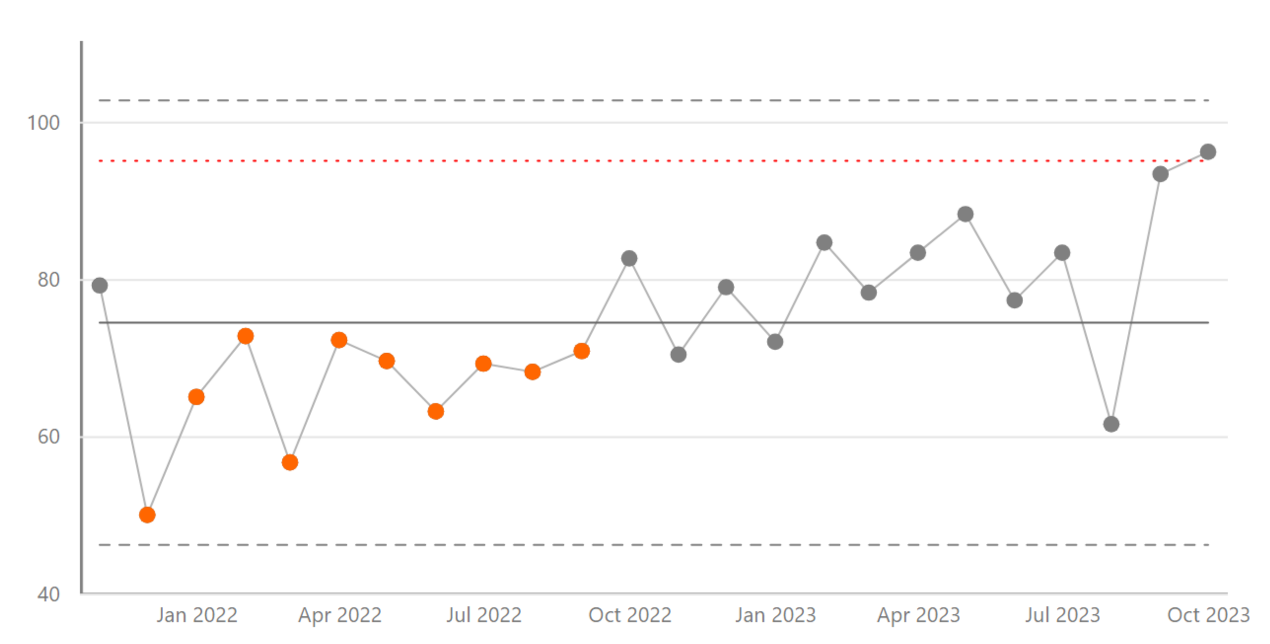
The standard for this indicator is within the upper and lower control limits

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	95.8%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	100.0%	95.0%		
South Locality Care Group	100.0%	95.0%		

Feedback

What the chart tells us

96.2% of routine referrals waited <4 weeks in October, which is within the expected range of 46% and 102%. This range suggests that the standard of 95% will rarely be achieved.

Root Cause of the performance issue

The metric does not reset the clock if a patient does not attend an appointment. Due to the small number of referrals each month, if one patient misses an appointment, this metric will be under the 95% target.

Improvement Actions

The service follows the positive engagement policy to improve access and manage DNAs.

Related to the 21/22 SDIP work, there are differences regarding how services are commissioned, resourced and delivered across the ICB, the services have been engaging with the ICB to develop 14 individual recommendations to improve CYPS ED services across the area. CNTW are currently waiting for the outcome of the 14 recommendations presented to the ICB.

Expected impact and by when

The current performance is above target; however, we are expecting continued variation each month because of DNAs.

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

Risk Rating - **High (Action)**

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

Actual/Forecast - -0.2M

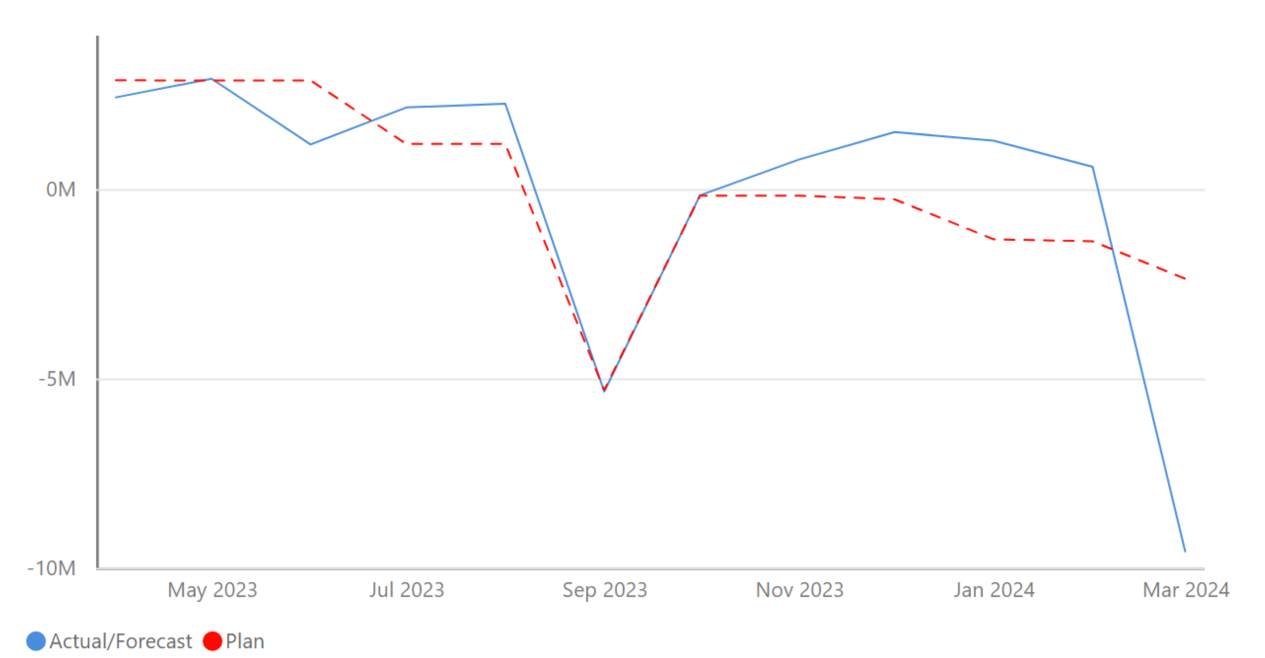
Plan - -0.2M

Not Applicable

Not Applicable

DQ - No Concern

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



Locality Name	Off Budget (£1,000)
Central	-113
North	78
North Cumbria	21
South	80
Corporate	-58

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.
- Shortfall in delivery of recurrent Cost Improvement Schemes is being offset with non-recurrent mitigations including release of the Annual Leave provision. Interest on cash balances from increased interest rates and further reviews of balances sheet totals.
- Pursing capital funding for CEDAR scheme to support Trust cash balances

9. SERVICE USER AND CARER EXPERIENCE REPORT - Q2

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

REFERENCES

Only PDFs are attached

9. Service User and Carer Experience report Quarter 2 2023-24 (002).pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6th December 2023
Title of report	Service User and Carer Experience Report – Quarter 2 2023
Executive Lead	Sarah Rushbrooke, Executive Director of Nursing, Therapies & Quality Assurance
Report author	Paul Sams – Feedback and Outcomes Lead
Purpose of the report	
To note	
For assurance	
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	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			Management meetings where this item has been considered	
Quality and Performance	25.10.23		Executive Team	23.10.23
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	x
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety and experience	x	Service user, carer and stakeholder involvement	x

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

CNTW Service User and Carer Experience Summary Report

Quarter 2 2023-24

Wednesday 6th December 2023

Executive Summary

Service users and carers offered most feedback for a quarter through the Points of You (PoY) survey in its current iteration during quarter 2 2023-24, with 1,596 experience surveys being completed.

A 6-week consultation period with service users, carers and staff to redevelop the Points of You survey has now been completed. Work to develop new questions has commenced with Speech and Language Therapy colleagues. A new experience survey is planned to be live from January 2024, which is outlined in Appendix A.

North Cumbria locality services, continue to have service users and carers expressing less satisfaction with their experience of services than all other localities and in comparison to Trust average, with a Friends and Family Test score of 7.7 out of 10 (Trust average score is 8.6).

The highest Trust score for a PoY question is 93% for people saying 'Yes' staff are kind and caring. South Locality scored highest with 96.5%, North Cumbria scored lowest with 84.8%.

The lowest Trust score for a PoY question is 83.7% for people saying 'Yes' they were given information that was helpful. South scored highest with 89.5%, North Cumbria had the lowest with 72.1% saying 'Yes'.

All staff have access to the PoY dashboard, however only 197 people accessed it during the quarter.

Recommendations

- Teams and wards to make efforts to make hard copy surveys available to service users and carers. Making attempts to identify when people would benefit from additional support to complete a survey or directing to other feedback options as appropriate.
- Teams and wards to make completing 'You Said – We Did' posters part of everyday business. Displaying them in public areas and discussing in team meetings as appropriate.
- Staff to familiarise themselves with the service user and carer feedback available on the Points of You dashboard (all staff have access to all data).
- Localities to understand reasons behind the lower response rate for people 'receiving information that was useful'.

- Teams to ensure the POY results for their area are discussed at their Service User and carer meetings and Quality Standards meetings, developing a plan for improvement where necessary and sharing their feedback widely.

Feedback Overview

The Points of You (PoY) survey remains the most popular way service users and carers offer feedback on their experience of services, with a record high of 1596 being completed during the quarter. As a result, the majority of this report will explore this type of feedback.

Service users and carers are also able to feedback their experience through Healthwatch, Care Opinion, The NHS website, via Complaints and PALS. The last 2 options are reported locally and to the Trust in other assurance forums.

The graph below shows the numbers of PoY surveys over the last 5 quarters, with the current quarter on the right-hand side.

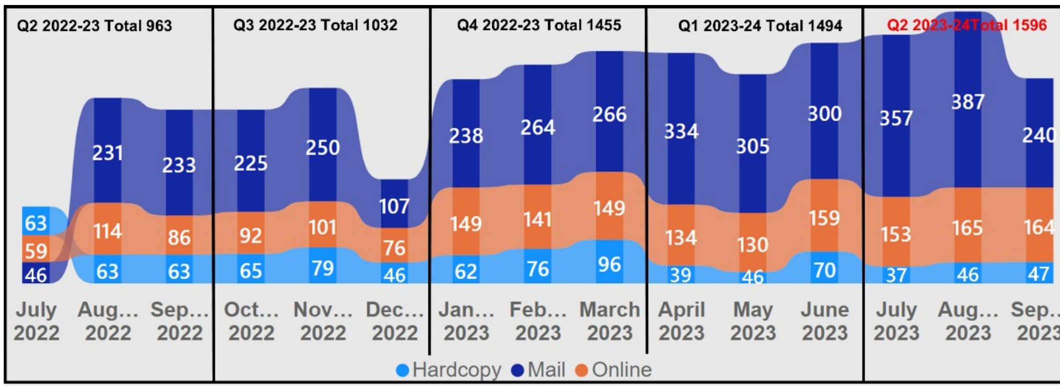
Graph 1 shows that there has been a rise in feedback numbers for the last 5 quarters, with this quarter offering the highest feedback since the current PoY survey was introduced in September 2020, which followed a similar trend.

The increase in survey returns is due to more regular use of the online survey, with 483 being completed in this way during the quarter, an increase on the previous best quarter (Quarter 4 2022-23) when 439 were completed. This was 60 more than the previous quarter (Quarter 1,423 online surveys).

There was also an increase in mailshot surveys being returned when compared with the previous quarter, with Quarter 1 2023-24 having 939 mailshot surveys and this quarter having 984.

Both increases continue a trend for record returns through online and mailshot options being completed by service users and carers. This is at a time when hard copy survey numbers continue to be low when compared to the numbers of surveys being requested and sent to teams. In fact, this quarter (130 hard copies) and the previous quarter (155 hard copies) have seen the lowest returns by quarter since this survey was introduced in September 2020.

As feedback levels are at an all-time high, this is a good time for staff to be looking regularly at the dashboard to make sure they are being reactive to emerging themes. In this quarter 195 staff members accessed the dashboard a total of 1,797 times (excluding Feedback & Outcomes Lead and Data Entry Officer leading on PoY).



Graph 1. Feedback through PoY by quarter and survey type

1,011 (63.3%) of the 1,596 surveys completed during the quarter came directly from service users. A further 163 (10.2%) were completed by someone on behalf of a service users. 355 (22.2%) surveys were completed by carers and 67 (4.2%) were completed by someone not specifying if they were a service user or carer.
South Locality continue to gain the most feedback for a locality, with 35% of all feedback received by the Trust during the quarter.

The Memory Protection Service (Sunderland) with 96 surveys and the Neurorehabilitation Outpatient Team with 61 surveys, stand out as the teams with excellent levels of feedback. Although it should be noted that of the 157 surveys for these teams, 140 are mailshot surveys. This means that both teams are almost totally reliant on this method for their feedback.

North Cumbria locality continue to receive the least amount of feedback, although it should be noted that this quarter is their highest level of returns for any quarter. The locality is far less reliant on mailshot than other localities, with online surveys being completed in higher numbers in recent quarters.

Memory Matters and Later Life Service (East) with 40 surveys, North Cumbria East CTT with 27 surveys and Memory Matters and Later Life Service (West) with 24 surveys stand out as having the highest levels of returns. However as with the high performing South locality teams, the Memory Assessment teams are heavily reliant on mailshot for their feedback.

Central Locality have the highest proportion of their feedback from sources other than mailshot, with 205 (46%) of their 449 responses being offered through online and hard copy surveys. Central also had the highest number of online responses of any locality with 184 being completed during the quarter in relation to their services.

North locality saw the biggest increase in feedback when compared with the previous quarter, rising to 309 from 205, a 51% increase. Northumberland Memory Service (47 surveys), Northumberland Children and Young Peoples Service (35 surveys) and Northumberland Community Learning Disability CTT (24 surveys) all have really good response levels.

It should also be noted that the team with the 6th highest level of feedback with 14 surveys is Bluebell Court, outperforming the closest inpatient wards, Alnmouth, Embleton and Kinnersley who all have 7 completed surveys each.

Locality	Quarter 2 (2022-23)	Quarter 3 (2022-23)	Quarter 4 (2022-23)	Quarter 1 (2023-24)	**Quarter 2 (2023-24)**
South	393	377	455	603	**553 (-8.3%)**
Central	240	269	453	448	**449 (+0.2%)**
North Cumbria	142	184	226	222	**253 (+14%)**
North	178	183	293	205	**309 (+50.7%)**
Others*	10	19	31	16	**32 (+100%)**
Total	963	1,032	1,458	1,494	**1,596 (+6.8%)**

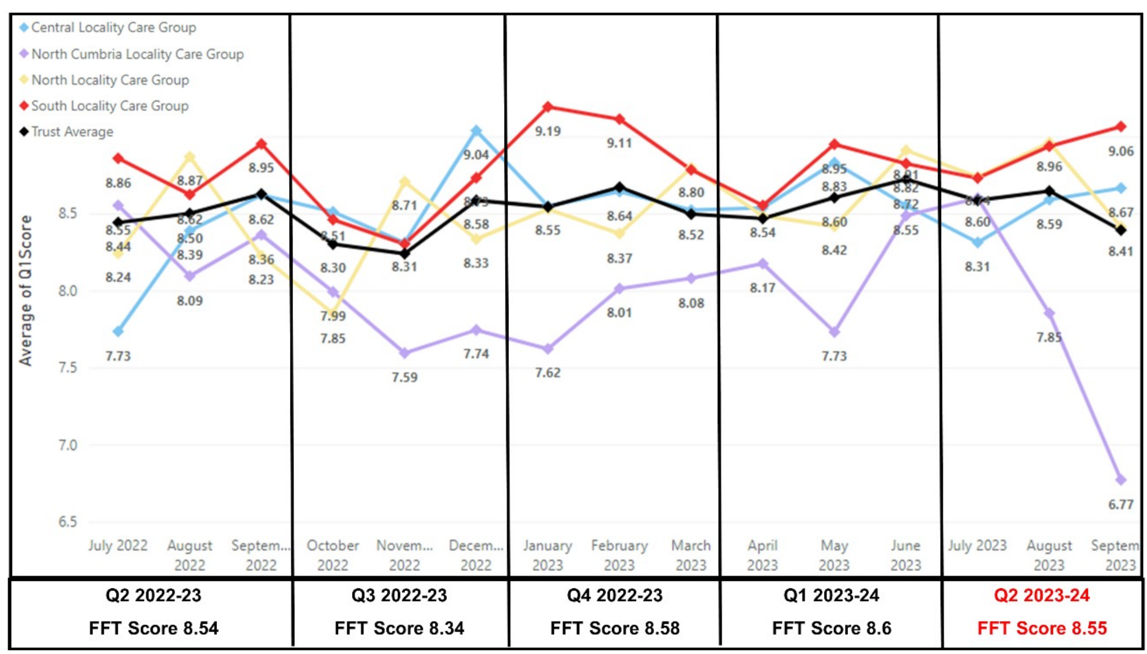
Table 1. Feedback by locality breakdown *teams not assigned to a locality

The average Friends and Family Test (FFT) score for the quarter was 8.55 out of 10, this is question 1 of the PoY survey. This is around the average score for a quarter when compared with the previous 4 quarters, see graph 2 below.

South Locality continue to have an average FFT score that trends above the Trust average, with an average score for the quarter of 8.91 and a peak score in September of 9.06, the only locality to gain a score over 9 during the quarter.

North Cumbria locality had the lowest average FFT score of any locality during the quarter with 7.76. The localities peak score was 8.6, however this score declined across the quarter to a low point in September of 6.77, this is the lowest monthly score for a locality since the current survey was introduced.

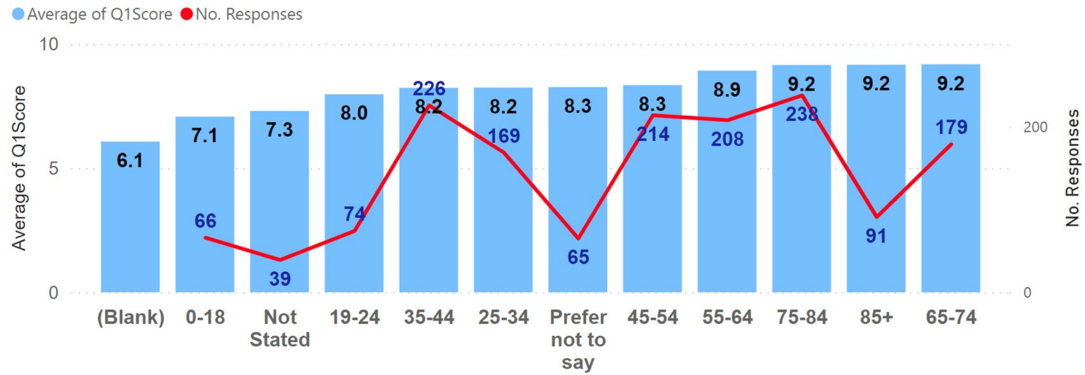
Most negative experiences related to Adult (13 negative and 30 positive surveys) and CYPS (6 negative and 25 positive surveys) community teams as well as Adult PICU (4 negative and 2 positive surveys) and CYPS inpatient wards (5 negative and 11 positive surveys).



Graph 2. Friends and Family Test score by locality and Trust average

Central locality had an average FFT score of 8.49 for the quarter, slightly below the Trust average. This was due to a low average of 8.31 in July that steadily tracked upwards to the peak score in September of 8.67.

North Locality had an average FFT score of 8.7 for the quarter and maintained an average monthly score that was above the Trust average in each month for the first quarter since the current experience survey was introduced in September 2020.



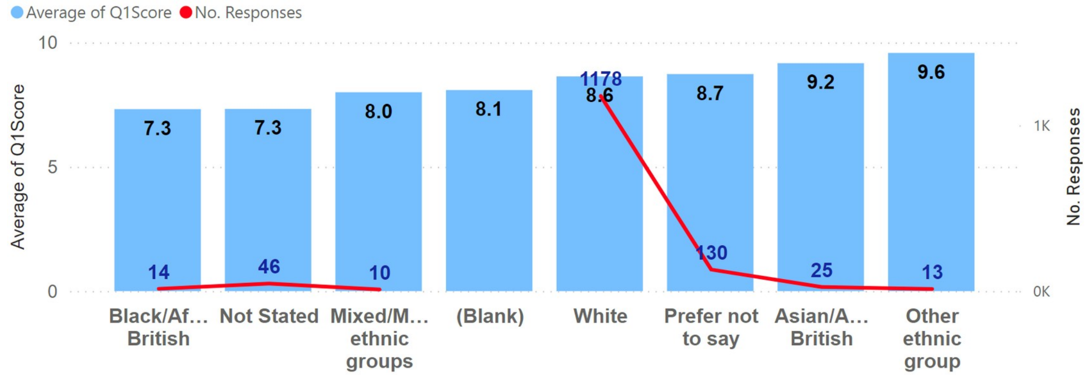
Graph 3. Satisfaction rating by age

Graph 3 above shows the satisfaction rating of people completing the FFT question by age. A trend continues of people under 18 reporting to be least satisfied after people who left this demographic blank when completing the survey.
Of the 66 children or young people sharing their experience, 5 chose ‘Poor’ and 4 chose ‘Very Poor’ to describe their experiences. These experiences relate to inpatient care on 5 occasions and community care on 4 occasions.

It is notable that all age categories up to age 54 are below the Trust average FFT score accounting for 853 (54% of surveys completed) experiences, with people older than 54 being more satisfied than the Trust average accounting for 716 (45% of surveys completed) experiences.

The chart below shows satisfaction ratings by ethnicity for people answering the FFT question. 14 people choosing ‘Black/African/Caribbean/Black British’ as their ethnicity offered the lowest satisfaction rating of 7.3 out of 10. When looking at individual responses 2 people offered the response ‘Poor’ to describe their experience, both relating to child and adolescent mental health wards. Comments on both occasions related to not feeling listened to or being ignored when in crisis.

People choosing ‘Other Ethnic Group’ had the best satisfaction rating this quarter from 13 completed surveys. Within this group everyone answered, ‘Very Good’ (10 occasions) and ‘Good’ (2 occasions) with a further person not answering this question by ticking an option however they did give a text response. Staff values were the most common theme for comments from this group of experiences.

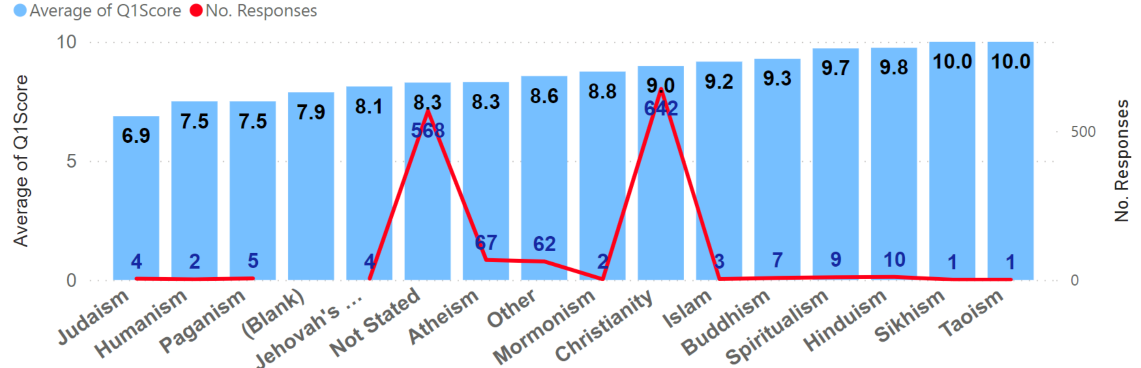


Graph 4. Satisfaction rating by ethnicity

Graph 5 below shows satisfaction ratings by religion. Unfortunately, people choosing 'Judaism' as their religion are reporting the worst experience, with a score of 6.9. When looking at these 4 surveys, it is reassuring to note that 1 person chose 'Very Good', 1 person chose 'Good' and 2 people chose 'Neither Good nor Poor'.

3 of the 4 surveys related to older people's services (2x mental health ward and 1x community mental health teams) and staff being friendly and supportive. One person did say there was no consistency in care.

The most chosen religion this quarter is Christianity with 642 surveys, offering an average satisfaction rating of 9 out of 10.

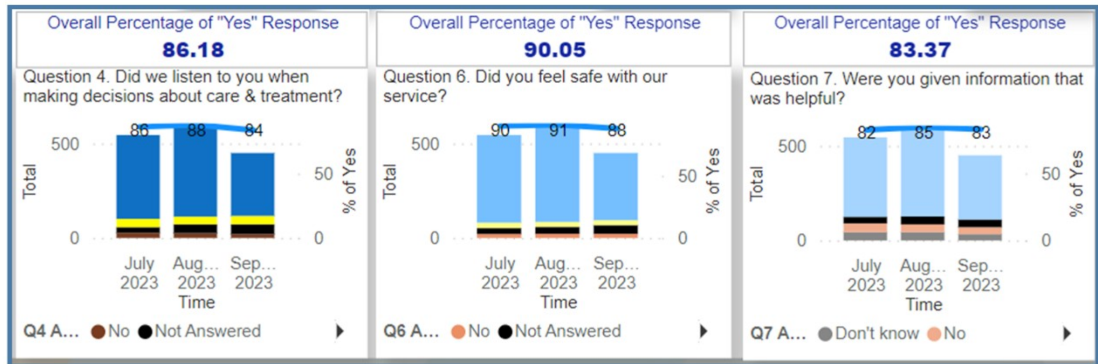


Graph 5. Satisfaction rating by religion

Questions 4, 5, 6 and 7 also offer the opportunity to measure satisfaction of service users and carers, as well as offering the chance to explore who is having the best and worst experience of our services, through exploring the demographics, when they have been completed (Note Questions 2 and 3 are text only answers and will be discussed in the thematic analysis section).

Each quarter one additional question will be discussed in detail alongside the FFT question. For quarter 2 the focus will be on question 5, 'were staff kind and caring?'

Below is an overview of Questions 4, 6 and 7 as they will not be explored in detail this quarter. This shows the monthly and quarterly percentage scores of people answering 'Yes' to each question.



Graph 6. Average scores for questions 4, 6 and 7

For question 4 ‘Did we listen when making decisions about care and treatment?’, 86% of people (1,262 surveys) offered ‘Yes’ as their response. It is evident that people over 55 feel far more listened to than people below that age range.

73 people said they didn’t feel listened to. Most ‘No’ answers relate to adult mental health community services, with 23 surveys or 31.5% of the ‘No’ responses to the question. 11 or 15% of the ‘No’ responses relate to specialist community children’s and young people’s services. The remainder are split between mental health places of safety (8), adult PICU (8) and long stay adult rehab (5). The remainder are services with less than 3 ‘No’ responses.

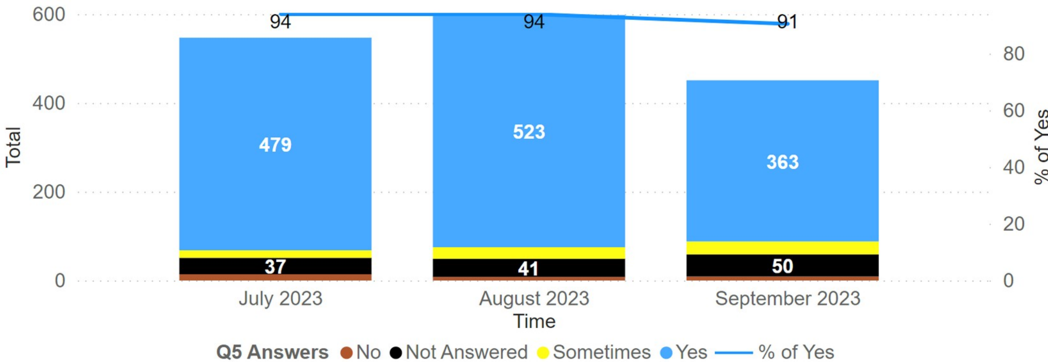
For question 6 ‘Did you feel safe with our service?’, 90% of people (1,334 surveys) offered ‘Yes’ as their response. When looking at demographic profiles for this question, people over 55 feel most safe with each age group over this point saying ‘Yes’ between 93% and 98% of the time.

The under 18 age group report feeling least safe, with 73% (47 of 64 surveys) offering ‘Yes’ as their response to this question. 9% (6 of 64 surveys) said ‘No’ they didn’t feel safe. These related to 4 surveys about community teams and 2 relating to inpatient teams. Waiting for support or not being listened to appear as the main comment themes around ‘No’ responses.

For question 7 ‘Were you given information that was helpful?’, 83% (1,232 of 1,478 surveys) of people answered ‘Yes’ as their response. 8% (122 surveys) of people answered ‘No’ and a further 8% (124 surveys) offered ‘Don’t Know’ as their response.

As discussed for other questions, under 18s report less often than older service users and carers that they were given useful information, with 67% (42 of 63 surveys) saying yes and 16% (10 saying no).

Question 5 is ‘Were staff kind and caring?’. Service users and carers have the option to answer ‘Yes’ ‘No’ and ‘Sometimes’ in response to this question. This question is most often the one that offers the highest percentage of people answering ‘Yes’. This quarter 1,365 people answered ‘Yes’, this was 93% of the 1,468 people who chose to answer this question. In comparison, 31 people chose to answer ‘No’ to this question, this is 2% of people answering the question.

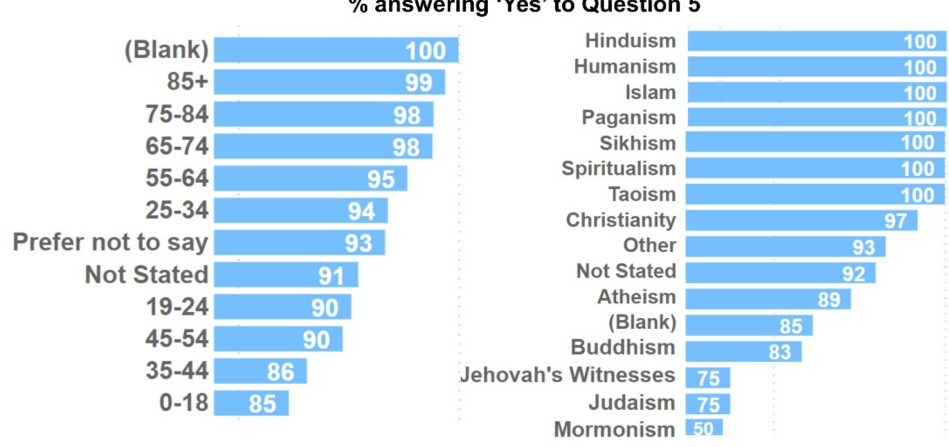


Graph 7. Average scores for question 5

The graphs below (8 & 9) show what percentage of people answered ‘Yes’ when responding to this question by various demographics.

Graph 8 shows responses by the age and faith demographics. As with previous discussions, under 18s offer the lowest percentage of people saying yes, however it should be noted that this low number is 85%. The next age category, 19-24 said yes 90% of the time and the category above, 25-34 said yes 94% of the time.

When looking at the faith demographic, Mormonism, Judaism and Jehovah’s Witnesses stand out as saying ‘Yes’ less often than other service users and carers. It should be noted that these experiences relate to 10 experiences. These surveys relate to older people’s community mental health teams (5 surveys), adult mental health inpatient or PICU wards (3 surveys) with a single survey each for a CYPS ward and an adult community mental health team.



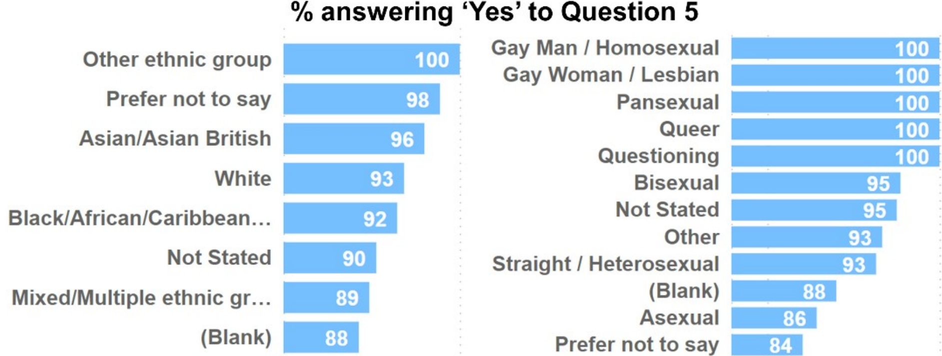
Graph 8. % answering ‘Yes’ to question 5 by age and faith demographics

Graph 9 shows responses by the ethnicity and sexuality demographics. People who chose mixed/multiple ethnic groups offered ‘Yes as their response least often of the identifiable groups with 89%. This score related to 10 surveys, with these being for a variety of teams, 8 community, 1 inpatient and 1 mental health place of safety.

The highest score is from people choosing other ethnic group and relates to 13 surveys, all of whom said ‘Yes’ to the question. 5 surveys relate to inpatient mental

health or PICU wards and the remainder are in relation to adult or older adult community mental health teams.

When looking at sexuality, the lowest score is for people choosing asexual with 86% saying yes. This relates to 7 surveys, all of which are adult community teams. Of the 7 surveys, 6 answered 'Yes' to this question and 1 person said 'Sometimes'.



Graph 9. % answering 'Yes' to question 5 by ethnicity and sexuality demographics

Independent Feedback Platforms

On 3 occasions people shared their experience through external websites, twice on the NHS website (both were pulled through to Care Opinion, as per the agreement between both sites) and once on Care Opinion.

Both stories on the NHS site were negative in nature and the one shared on Care Opinion was positive. All three were offered a response and the relevant team informed to contribute to this response when they were identified.

Thematic Analysis

When completing a PoY survey, service users and carers have the opportunity to tell us about their experience in relation to the 7 questions. This generated 6,733 comments during the quarter that were all themed. 74.6% (5,023 comments) of these comments were positive in theme, with a further 2.4% (164) being a compliment about a person or a team. 16.1% (1081 comments) were negative in theme and 6.9% (465 comments) were neutral comments.

The table below shows the main theme for the comments received, highlighting the dominant themes across quarter 2 2023-24 and allows a comparison across the previous 3 quarters.

Communications, Patient Care and Values and Behaviours continue to be the most often discussed themes across all 4 quarters shown, a situation that has continued across the life of the current PoY survey (introduced in September 2020).

Theme Category	Quarter 3 2022-23				Quarter 4 2022-23				Quarter 1 2023-24				**Quarter 2 2023-24**			
	Compliment	Positive	Neutral	Negative	Compliment	Positive	Neutral	Negative	Compliment	Positive	Neutral	Negative	Compliment	Positive	Neutral	Negative
Access to Treatment or Drugs		0.45%	1.82%	2.10%		0.70%	2.99%	3.34%		0.35%	2.52%	1.20%		0.26%	0.65%	1.03%
Admissions and Discharges		0.10%		1.21%		0.04%	0.43%	0.81%		0.04%	1.05%	0.80%		0.04%	0.22%	0.75%
Appointments		1.66%	5.00%	5.85%	1.02%	1.76%	3.85%	3.61%	2.04%	2.34%	1.89%	4.98%	0.61%	1.68%	3.02%	5.70%
Clinical Treatment	0.67%	0.39%	1.36%	0.44%		0.65%	1.07%	1.08%		1.10%	0.84%	1.10%		0.68%	1.94%	1.40%
Communications	30.00%	35.57%	32.73%	42.27%	29.08%	33.12%	23.29%	36.10%	29.93%	32.74%	32.49%	36.55%	22.42%	32.10%	29.81%	35.61%
Facilities	0.67%	1.20%	5.91%	5.96%	0.51%	1.00%	3.63%	6.77%		1.08%	3.14%	9.56%	0.61%	0.94%	3.89%	7.66%
Other		0.06%	5.45%	0.11%		0.47%	22.86%	0.90%		0.24%	16.56%	0.60%	1.21%	0.38%	22.03%	1.40%
Patient Care	25.33%	29.60%	33.64%	24.28%	30.61%	30.93%	29.06%	25.27%	16.33%	26.93%	24.32%	21.71%	14.55%	26.41%	23.54%	21.40%
Prescribing		0.13%	0.91%	0.88%		0.55%	1.28%	1.26%		0.39%	0.84%	1.00%		0.10%	0.65%	0.37%
Privacy, Dignity and Wellbeing	1.33%	0.16%				0.43%	0.21%	0.45%		0.08%	0.42%	0.40%		0.02%		0.09%
Staff Numbers		0.06%	2.27%	2.54%		0.06%	1.50%	3.97%		0.04%	1.47%	3.19%		0.14%	2.16%	2.52%
Trust Admin/ Policies/Procedures		0.03%		0.33%		0.04%	0.85%	0.81%		0.20%	0.63%	0.40%		0.10%	0.22%	1.31%
Values and Behaviours	42.00%	30.31%	7.73%	7.51%	38.78%	29.74%	6.62%	6.05%	51.70%	33.82%	10.90%	8.76%	60.61%	36.82%	9.29%	11.78%
Waiting Times		0.26%	3.18%	6.51%		0.51%	2.35%	9.57%		0.65%	2.94%	9.76%		0.34%	2.59%	8.97%

Table 2. Themes by quarter

It is interesting to note that the communications theme remains the most dominant one and has done across the quarters shown in Table 2. The positive and compliment themed comments have declined in line with a reduction in negative comments. This coincides with a steady rise in positive and negatively themed comments relating to the values and behaviours theme.

The following are representative comments from the sub-themes 'Staff/Service User' and 'Being Listened To' sub-themes of the Communication theme, these are the dominant sub-themes this quarter:

Positive examples:

'Fantastic service from start till finish. Your team have always been very willing to help and listen' - Adult Autism Diagnostic Service

'My key worker is always so helpful and understanding he always listens to me and really shows he cares about me' - Newcastle Treatment and Recovery Service
'I have been given appropriate medication when I asked and I have not been forced to do anything I did not want to' - North Cumbria Community Child and Adolescent Mental Health Service

Negative examples:

'you had a meeting with school teachers and I felt as though I wasn't kept in the loop about this and had to invite myself as a parent' - ICTS (Children and Young People's Intensive Community Treatment Service) - Northumberland & North Tyneside

'I feel like some of the things i suggested were just blown over' - CEDS-CYPS (Community Eating Disorder Services) North Cumbria

'Didn't ring when they said they were going to. Loads of appointments cancelled because a member of staff was on the sick and when were finally seen him we were told they'll have to talk to adult services because he's not 18 and again they never called us with a follow up' - North Cumbria Attention Deficit Hyperactivity Disorder (ADHD) Children and Young People's Service.

Specialist Services

Team	July-23	Aug-23	Sept-23	Average FFT Rating
Perinatal Inpatient (Beadnell)	1	0	2	9.2
Mental Health and Deafness	0	0	0	No score available
Gender Dysphoria Service	0	4	2	9.2
Low Secure Services (Adult)	5	8	8	8.3
Medium Secure Services (Adult)	29	25	21	7.9
CAMHS Ferndene	0	12	5	6.2
Lotus Ward	0	2	0	7.5
CAMHS Medium Secure (Alnwood)	0	0	0	No score available
Eating Disorders (Inpatient)	0	0	0	No score available
Eating Disorders (Day Service)	0	0	0	No score available

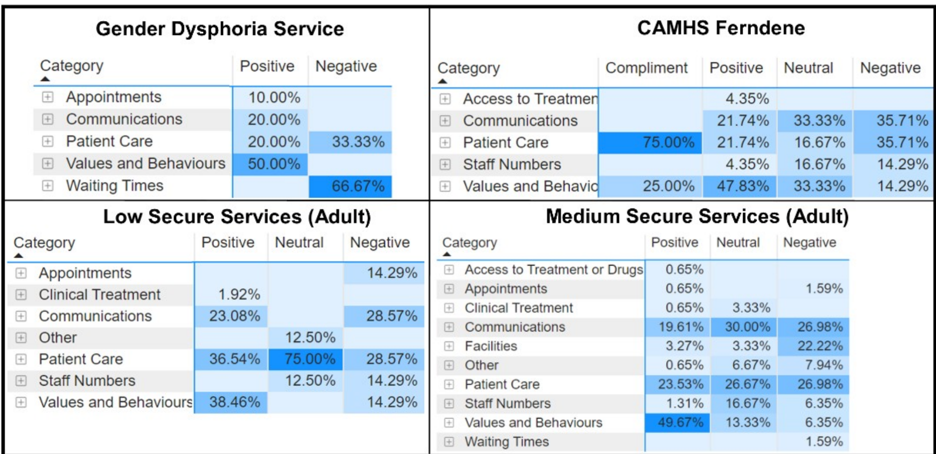
Table 3. Feedback and FFT satisfaction rating for specialist teams

Within specialist services, 4 services received no feedback at all. This should be addressed as a priority by the teams and can be supported by the Trust Feedback and Outcomes Lead to develop strategies. 2 services have received small numbers of feedback during the quarter.

Adult Medium Secure Services (75 surveys), Adult Low Secure Services (21 surveys), CAMHS Ferndene (17 surveys) and Gender Dysphoria Services (6 surveys) all received enough feedback to be able to explore.

It is notable that all services have themes which are similar to those prominent in feedback more generally in all feedback received by the Trust this quarter. This is with the exception of Gender Dysphoria Services where waiting times make up over 66% of negative comments.

The themes of the 4 services that received good levels of feedback are shown in the table below.



Gender Dysphoria Service

Category	Positive	Negative
Appointments	10.00%	
Communications	20.00%	
Patient Care	20.00%	33.33%
Values and Behaviours	50.00%	
Waiting Times		66.67%

CAMHS Ferndene

Category	Compliment	Positive	Neutral	Negative
Access to Treatmen		4.35%		
Communications		21.74%	33.33%	35.71%
Patient Care	75.00%	21.74%	16.67%	35.71%
Staff Numbers		4.35%	16.67%	14.29%
Values and Behavic	25.00%	47.83%	33.33%	14.29%

Low Secure Services (Adult)

Category	Positive	Neutral	Negative
Appointments			14.29%
Clinical Treatment	1.92%		
Communications	23.08%		28.57%
Other		12.50%	
Patient Care	36.54%	75.00%	28.57%
Staff Numbers		12.50%	14.29%
Values and Behaviours	38.46%		14.29%

Medium Secure Services (Adult)

Category	Positive	Neutral	Negative
Access to Treatment or Drugs	0.65%		
Appointments	0.65%		1.59%
Clinical Treatment	0.65%	3.33%	
Communications	19.61%	30.00%	26.98%
Facilities	3.27%	3.33%	22.22%
Other	0.65%	6.67%	7.94%
Patient Care	23.53%	26.67%	26.98%
Staff Numbers	1.31%	16.67%	6.35%
Values and Behaviours	49.67%	13.33%	6.35%
Waiting Times			1.59%

Table 4. Themes of Specialist Services feedback received during quarter 2 2023-24

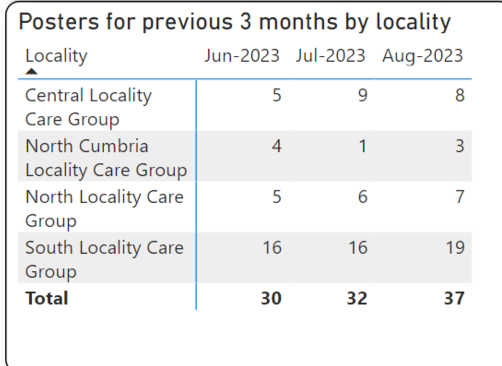
How are we responding to feedback?

Each team has the opportunity to create a You Said-We Did (YSWD) poster, using a template built into the Points of You dashboard. This system was created to support

teams and wards to be responsive to feedback and experience on a monthly basis, with a process designed to be easy to use and therefore not using up precious clinical time and resources.

This process has been and continues to be discussed at Trust, Locality, CBU and team/ward level, supported by awareness sessions, user guides and good practice guidance being readily available.

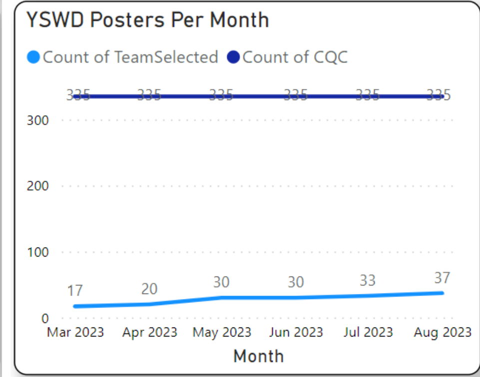
We are aware that teams and wards are responsive in other ways when they receive feedback. This system is a helpful tool to be able to show a methodical approach over time, something that would help to evidence patient experience for regulatory requirements such as CQC inspections or PLACE visits.



Posters for previous 3 months by locality

Locality	Jun-2023	Jul-2023	Aug-2023
Central Locality Care Group	5	9	8
North Cumbria Locality Care Group	4	1	3
North Locality Care Group	5	6	7
South Locality Care Group	16	16	19
Total	**30**	**32**	**37**

Table 5. YSWD posters by locality



Graph 8. YSWD posters Trust view

This quarter saw the highest levels of teams producing their own YSWD posters. Graph 8 shows there was a month on month rise demonstrating that some teams are completing this process for the first time. This increase is due to a sustained attempt through locality and Trustwide awareness discussions taking place across the quarter.

The peak month for poster production was 37 posters during September. During this month 161 teams had feedback, so had the opportunity to develop a poster.

South Locality continue to create the most YSWD posters with their peak month in September with 19 posters, in a month when 47 teams could have created one.

North Cumbria locality created the lowest numbers of posters, with the peak month being July when 4 were created. 29 teams had feedback available to respond to during that month.

For support with Points of You and You Said-We Did, please get in touch with paul.sams@cntw.nhs.uk and copy in poy@cntw.nhs.uk and we will get back to you promptly.

Appendix A

Developing a new Service User and Carer Experience Survey

Executive Summary

The current Points of View (PoY) survey was introduced 3 years ago and has been. Completed over 12500 times since then.

In 2023 we have taken the opportunity to review the current POY survey to support a number of factors:

- Trust branding has recently changed, meaning a redesign of PoY is required.
- The PoY identifier can no longer be used, offering the opportunity to look at the name of the survey.
- More digital and inclusive options to complete the survey are now available and can be incorporated into this review.
- There is an opportunity to align new survey questions to the commitments within the new Trust strategy.
- This has provided an opportunity to engage with people around what they want from an experience survey.
- Encouraging service users and carers from harder to reach groups and services to engage in providing feedback e.g., learning disability and autism services and children's services.

The following report sets out how we have engaged with service users, carers and staff, exploring what we have learned through this process, as well as the next steps involved in creating a new survey.

287 people expressed their views during the 6-week engagement process. The main themes highlighted:

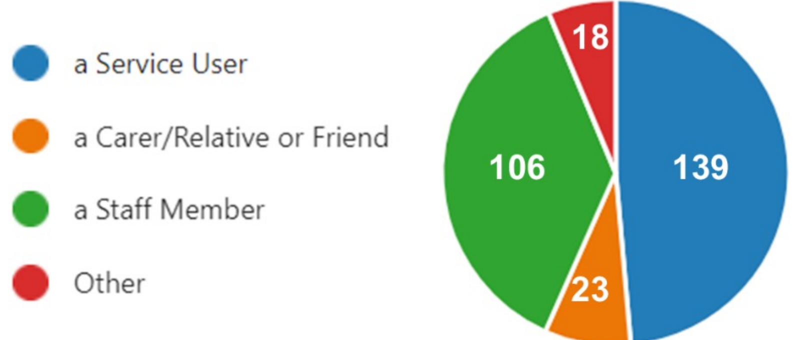
- A preference for digital opportunities to complete surveys.
- The most important themes for questions were:
    - A question about Quality of Care
    - A question about Experience
    - A question about Person-Centred Care
- People wanted the following questions from the current survey to be kept:
    - Did we listen when making decisions about care and treatment?
    - Were staff kind and caring? – Quality of care was the main theme for suggested questions.

Engagement

There was a mixed method approach taken to engaging and consulting with service users, carers and staff. This included:

- An online survey
  - This was communicated through the Bulletin, the Trust's social media profiles and through the Voluntary Organisations Network North East (VONNE). Thank you to everyone who supported getting the message out.
- Engagement sessions
  - These were a mix of in-person and online discussions which included service users, carers and staff.
  - There was a session involving a young person from the newly developing CYPS Involvement Bank.
  - A big thank you to the Involvement Team for their support.
- Pop-Up engagement sessions
  - There were 4-hour sessions at Trust community and inpatient sites in all localities. This allowed people who ordinarily might not get involved in this type of engagement a chance to contribute.
  - Thank you to St Nicholas Hospital, St Georges Park, Hopewood Park, Carleton Clinic, Walkergate Park, Ferndene, Silverdale and the Service User and Carer Reference Group for supporting conversations to take place.
  - Thank you to all of the locations that invited us to be in waiting areas and foyers.

During this engagement 287 people expressed their views. Below is a breakdown of who took the opportunity to get involved.

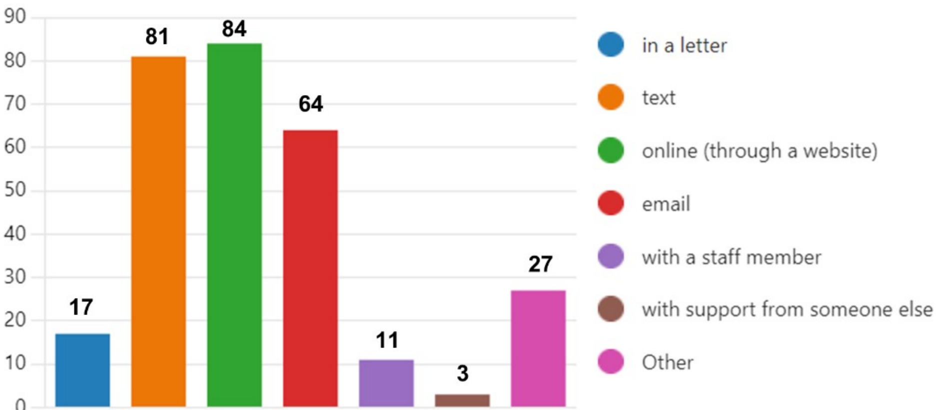


People choosing 'Other' include a number of combinations, including 'Staff and Service User' 'Staff and Carer' or Service User and Carer'. One person chose not to say.

People's preference for engaging with a survey

As part of the engagement process people were asked what their preference for receiving an experience survey was. The table below shows that there was a significant theme of people preferring digital options in over physical options.

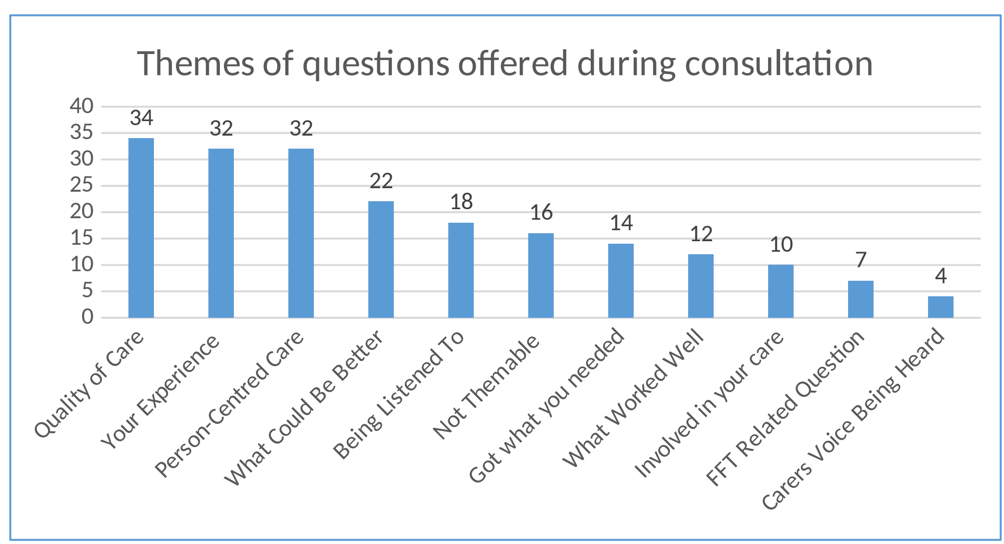
People choosing ‘Other’ had the option to explain and ‘all of the above’ and ‘multiple options’ were the most common responses offered.



Themes for new questions

The table below shows the main themes from the questions that people offered as being important to them.

Quality of care, Experience and Person-centred care were evident as important to most people.



*Not themable mostly included questions relating to staff experience or people saying they couldn’t think of a question.

What people wanted to keep from the current PoY survey

There were 4 engagement sessions (2 on Teams and 2 in person) that were open to people from the Involvement Bank as well as staff. These sessions were attended by 27 people.

During these sessions there was a discussion focussed on the current PoY questions, Allowing people the opportunity to say what questions they would want to keep or remove, as well as what adaptions people would like to make to keep some questions.

- Question 1 is the Friends and Family question so must remain as is.
- Question 2 – What things could have been better about the service?
  - This was the 4th most common theme of questions offered through all engagement.
  - People suggested rewording – specifically the word 'service'
- Question 3 – What did you find good/helpful about the service?
  - This was the 8th most common theme for questions offered through all engagement.
  - Mostly people discussing this question asked if it could somehow be combined with question 2.
  - One person suggested taking the positive and negative out of questions 2 and 3 would leave the person the choice of which to discuss without being directed.
- Question 4 – Did we listen when making decisions about care and treatment?
  - Person-centred care was the joint 2nd most popular theme and being listened to was the 5th most common theme for questions proposed by people. Both align with this question.
  - Consensus was that this question is important but needs changing to be more accessible.
- Question 5 – Were staff kind and caring?
  - Quality of Care was the main theme of question offered.
  - Themes from conversations around this question centred on the addition of 'care being effective' or this being the main theme of this question or at least as important.
- Question 6 – Did you feel safe with our service?
  - This did not appear as an important theme through the online survey or in pop-up conversations.
  - In engagement sessions there was a number of comments around safety meaning different things to different people. It was suggested that an information bubble should be added to explain it if it stays as a question.
- Question 7 – Were you given information that was helpful?
  - This did not appear as an important theme through the online survey or in pop-up conversations.
  - A theme from engagement sessions was that this should be changed to 'Did you get the information you needed?' or similar.

Developing the new questions (see appendix 1)

- We have worked with Speech and Language colleagues from all types of service to develop new questions that include adapted versions of the current questions that have been identified as important.

- We have developed these questions and any replacements to cover the main themes identified through the engagement process.
- Questions have been developed to ensure the information offered in response to them is usable to individual teams and the organisation. This will be by a tick box response that will offer an overall score, as well as an option to give a written response that will be themed. Both will be incorporated into the feedback dashboard currently under development.
- New questions have been developed supporting the Trust to understand how effectively we are delivering on the commitments set out in the current strategy.

Next steps

- Once questions are agreed, a new survey will be developed to go live online and in physical formats. Consideration made to additional accessibility features that will support more people to share their experiences should they wish.
- We will explore a new name for the experience survey through the Trust weekly question. This is as the current identifier and is being retired in line with current Trust guidance.
- This provides an opportunity to raise awareness with service users, carers and staff of the importance of feedback to the Trust. This will include promoting the use of the You Said – We Did function that supports teams to be responsive.
- Develop information for service users, carers and staff to advise that sharing a mobile number or email address could lead to an experience survey being sent out, unless the person opts out.
- The aim is to launch the new survey in January 2024.

Appendix 1 – Proposed new experience survey questions:

Note question 1 is the Friends and Family Test (FFT) question and cannot be changed in either wording or response layout.

1. Overall, how was your experience of our service?

Very Good ☐ Good ☐ Neither Good nor Poor ☐ Poor ☐ Very Poor ☐ Don't Know ☐

Tell us why here

2. How was the care we provided?

Very Good ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐ Don't Know ☐

Tell us why here

3. How involved were you in the care?

Not involved ☐ Somewhat involved ☐ Very involved ☐

Tell us why here

4. Did you feel safe with our service? (i) Opens up to explain 'safe'

Yes ☐ No ☐ Don't Know ☐

Tell us why here

5. Were you given information that was helpful? (i) Opens up to explain 'information'

Yes ☐ No ☐ Don't Know ☐

Tell us why here

6. How did we do with:

Medication Very Good ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐ Don't Know ☐

Treatment Very Good ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐ Don't Know ☐

Waiting times Very Good ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐ Don't Know ☐

Tell us why here

10. WORKFORCE ISSUES - NONE TO NOTE FOR THE PERIOD

Darren Best, Chair

11. HEALTH INEQUALITIES FRAMEWORK

Lynne Shaw, Executive Director of Workforce and OD

REFERENCES

Only PDFs are attached

11. Health Inequalities Leadership Framework.pdf

Name of meeting	Trust Board of Directors
Date of Meeting	Wednesday 6 December 2023
Title of report	Health Inequalities Leadership Framework Board Assurance Tool
Executive Lead	Lynne Shaw, Executive Director of Workforce & OD
Report author	Christopher Rowlands / Jane Welch

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		Management meetings where this item has been considered	
Quality and Performance		Executive Team	
Audit		Executive Management Group	27/11
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	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	X

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

Trust Board of Directors
Wednesday 6 December 2023

Health Inequalities Leadership Framework Board Assurance Tool

1. Executive Summary

The National Healthcare Inequalities Improvement programme is an NHS England and Improvement (NHSEI) programme to ensure that the NHS better prevents and responds to the health inequalities which many communities experience. This is particularly important as the NHS continues to recover and reset from the COVID-19 pandemic, which has exacerbated and highlighted these long-standing inequalities.

The NHS Confederation was commissioned to provide support and guidance on stronger NHS leadership action on health inequalities as defined in the NHS Long Term Plan. This has resulted in the development of a national leadership framework, established to address health inequalities. The framework assesses evidence for 8 key lines of enquiry using 5 priorities across each of the lines of enquiry.

The key lines of enquiry are:

1. Leadership capability focused on achieving health equity.
2. Clear vision and credible strategy to deliver action on inequalities with robust delivery plans.
3. Equality and diversity are actively promoted in the workplace so that service access and delivery is high quality, sustainable and sensitive to the needs of all – and that staff health and wellbeing is being supported.
4. Clear responsibilities, roles and systems of accountability, to support good governance and management to tackle inequality.
5. Clear effective processes for managing risks, issues and performance, with focus on achieving equity.
6. Appropriate and accurate information available on progress against inequality.
7. People who use services, our communities, staff and external partners are involved and empowered to ensure services have excellent access, outcomes and experience for all.
8. Robust systems and processes for learning, continuous improvement and innovation to achieve equity.

These are examined across each of the 5 national priorities for health inequalities which are:

1. Restore NHS services inclusively.
2. Develop digitally enabled pathways inclusively.
3. Ensure datasets are complete and timely.
4. Proactively engage people at greatest risk in prevention.
5. Strengthen leadership and accountability.

We have gathered evidence across the Trust and mapped it against the assurance tool and have identified where there are gaps in our evidence which we are taking steps to

address. Once we have filled the gaps we will complete the scorecard which will clearly identify any areas where we need to take action. This will be reported through the relevant governance processes.

2. Key issues, significant risks and mitigations

A detailed list of evidence mapped against the key lines of enquiry is appended to this report. Trust Board of Directors is asked to note the following table which shows where currently there are gaps in the information.

	KLOE 1	KLOE 2	KLOE 3	KLOE 4	KLOE 5	KLOE 6	KLOE 7	KLOE 8
Priority 1 Restore NHS Services Inclusively	✓	✓		✓	✓		✓	✓
Priority 2 Develop digitally-enabled pathways inclusively	✓						✓	✓
Priority 3 Ensure datasets are complete and timely	✓	✓	✓	✓	✓	✓	✓	✓
Priority 4 Proactively engage people at greatest risk in prevention	✓✓	✓	✓		✓			✓
Priority 5 Strengthen leadership and accountability		✓	✓	✓	✓		✓	✓

- We are working with Digital Services to ensure that existing evidence for priority 2 is mapped against the key lines of enquiry. A regional Digital Inclusion strategy has been developed and a workshop has been arranged to take forward this important area of work.
- KLOE 6 Appropriate and accurate information available on progress against inequality will be addressed as part of work that will take place on the Patient Carer Race Equality Framework. The work of the Trust's Inequalities Data and Evidence Group is also closely aligned to the delivery of this objective.

3. Recommendation/summary

Trust Board of Directors is asked to note the following:

- Evidence gathered to date as part of this programme
- Work on the framework is an iterative process. Once we have evidence for each key line and priority, we will complete the scorecard and report back through the relevant governance processes with proposals for actions.

Christopher Rowlands
EDI Lead

Lynne Shaw
Executive Director of Workforce & OD

Appendix 1.

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
Health Inequalities Leadership Framework

Priority 1 – Restore NHS Services Inclusively

KLOE 1:

- It is recognised that individuals with severe mental illness and neuro disabilities form a significantly disadvantaged group. With that in mind the focus on efficient and effective community service delivery remains a key focus for the organisation recognising the range and scale of the community offer to children, adults and older people. The recent establishment of the Trust Community Oversight Meetings provides a forum to review clinical and performance data from a broad range of service elements identifying shortfalls to be addressed and promoting the sharing of good practice throughout the organisation. In addition to mainstream community services, we also review our performance against urgent care targets be they 1 hour and 24-hour targets within Liaison services and the “urgent and very urgent” targets that apply to crisis services. In the recognition that people access services via different routes, we have worked in collaboration with PCNs to promote the concept of ARRS workers, therefore taking high levels of expertise and knowledge upstream. In addition, we will soon be providing dedicated specialist mental health services to the general public within our catchment area via the introduction and implementation of the ‘111 select mental health’ option, therefore broadening access routes into care delivery.
- Service delivery dashboards.
- Equality Impact Assessments on all Trust policies.

KLOE 2:

- The CNTW ‘With you in mind’ strategy supports the CORE20plus5 framework, including a strategic ambition to work with and for our communities, addressing the wide inequalities that contribute to ill-health across our region. We will do this by reaching out and serving all communities, particularly those that are disadvantaged, to reduce inequalities and achieve fairer outcomes, and we also intend to use our power as an employer, as a purchaser and as a landlord to reduce inequalities. Our commitments to service users and communities are based on human rights principles and reflects what people want from us as an organisation.

KLOE 4:

- Restoring waiting lists to pre-pandemic levels remains a challenge for the organisation, particularly within some specialities e.g. children’s neuro. The Trust is going through a significant period of change aligned to the emerging community transformation developments which will highlight our role within the system as a Partner as well as a specialist provider. With this in mind, we are working with a broad range of partner organisations to ensure that asset mapping exercises accurately reflect and identify the available resources and skills that can be utilised for the benefit of the population that we serve. We recognise that not all individuals who have previously been in receipt of care from CNTW will continue to require our level of input but will require care from an alternative provider. As a specialist provider organisation, we regularly

review our available skills and competencies to ensure that they are effectively aligned to meet the needs of our client base. Very recently we have identified 7 Pioneer Teams within our place-based areas to be used as a pathfinder to implement change in a managed and considered manner.

KLOE 5:

- Severely negative feedback received through the feedback (non-complaint) options is shared with team leads and where appropriate a response if offered to the person on how the team intend to absorb that feedback.
- The organisation collates a broad range of clinical and demographic data that feeds into key performance reports which are a measure of progress. These reports can be used as a baseline to establish trajectories to be applied to teams, service areas or localities. This enables performance management to take place based on a sound performance measurement footing. Severe mental illness and neurological presentations are in themselves key issues that impact on timely access to care delivery and therefore the work that we undertake aims to increase access and interventions in a timely manner for the benefit of all.
- Developing a system of feedback that allows someone to have a survey completed on their behalf, either by family or carer/staff or someone independent. The system is well used so is reducing inequity of access.
- An accessible film has been in place for over 2 years on the online survey. This talks a person through how to complete the survey and is narrated BSL signed and has closed captions, it includes a visual walk-through of the form with explanations.
- Demographic questions were recently changed in response to feedback from the Gender Dysphoria team. These were developed with service users accessing that team. This work has led service users now giving regular feedback to that team which can be absorbed and responded to.
- The Trust has a well-established process in place to investigate complaints thoroughly to raise confidence in our services and improve the patient experience. Complaints are valuable learning tools and provide information that enables services to improve.
- The Trust’s complaints policy and accompanying Practice Guidance Notes have been written in line with the principles Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009 (2009 Complaints Regulations) and the Parliamentary Health Service Ombudsman’s good practice guidance.
- Complaints can be made in writing or direct to our dedicated telephone line or dedicated complaints email inbox. There is a complaint leaflet outlining the details to do this, which is also available in an ‘easy read’ format to help those with learning disabilities. Anyone who is struggling to make a complaint can be referred to the Patient Advice and Liaison Service (PALS). The service provides advice and support to service users, their families, carers and staff, providing information, signposting to appropriate agencies, listening to concerns. Complainants are also signposted to local advocacy services to support them in making a complaint.
- Themes from complaints are provided to individual services on request. In addition, there is also a six-monthly review of Trust-wide themes from complaint action plans

which is circulated widely with the aim of enabling services to examine their own complaint information with the aim of improving the quality of care.

- All complaints received and triaged for investigation and extensions requests receive Director oversight and are discussed weekly at the Trust-wide Safety Group. The Quality and Performance Committee regularly reviews the complaints received and identifies trends which are outlined in the monthly and quarterly Safer Care reports.
- Further gathering of feedback from service users:
  - Service User and Carer Reference Forum (quarterly), Points of You, CQC Community Mental Health survey focuses on adult service users' feedback.
  - The Trust is currently developing its latest version of the Points of You survey, the consultation process has gone out via a survey with nearly 11k responses so far.

KLOE 7:

- A new survey is currently being developed and has had co-production as a core principle. Service users, carers and staff were offered a range of opportunities (to suit different preferences and to reach people who would ordinarily be missed from this type of conversation) to share what is important to them for a survey to include. Speech and Language Therapists from a range of specialties (CYPS, Adult Mental Health, Autism and Learning Disability) then supported the development of accessible questions, based on the themes that emerged through the consultation process. This is planned to be in use by 1 January 2024.
- An online system of 'You Said – We Did' posters has been made available to all wards and teams to support them to show their stakeholders how they are being responsive to feedback with regularity and being responsive to recent feedback.
- Severely negative feedback received through the feedback (non-complaint) options is shared with team leads and where appropriate a response is offered to the person on how the team intend to absorb that feedback.

KLOE 8:

- The Trust feedback system follows the Ask-Listen-Do methodology and practices as much as possible. With the aim of supporting more people, especially but not exclusively people with a learning disability and autistic people to be able to interact with feedback options. Again, these considerations are important as the new service user and carer experience survey is being developed.

Priority 2 – Develop digitally-enabled pathways inclusively

KLOE 1:

- Service User Carer Reference forums (quarterly)
- Patient information team – The Centre aims to ensure that everyone has access to a range of useful health and wellbeing information resources. The service is free and completely confidential.
- The Patient Information Centre assists with the production of accessible information for patients, carers and the public. The team support the Trust's services to develop,

update and review patient, carer and public information resources. This includes information about services, conditions and treatments, self-help and wellbeing information and welcome guides. The team also ensures that patient and carer resources are available, accessible and updated in the resource library on the CNTW website. The team also responds to information requests from members of the public and organisations.

- Self-help guides available to all staff, service users, carers, and the general public.
- New Sharing Letters to Service Users Policy CNTW(O)22 – co-produced by service users, carers and CNTW staff (including feedback from the public via focus groups, internal communications, and external forums).

KLOE 7:

- A new survey is currently being developed and has had co-production as a core principle. Service users, carers and staff were offered a range of opportunities (to suit different preferences and to reach people who would ordinarily be missed from this type of conversation) to share what is important to them for a survey to include. Speech and Language Therapists from a range of specialties (CYPS, Adult Mental Health, Autism and Learning Disability) then supported the development of accessible questions, based on the themes that emerged through the consultation process. This is planned to be in use by 1 January 2024.
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KLOE 8:

- The Trust feedback system follows the Ask-Listen-Do methodology and practices as much as possible. With the aim of supporting more people, especially but not exclusively people with a learning disability and autistic people to be able to interact with feedback options. Again, these considerations are important as the new service user and carer experience survey is being developed.

Priority 3 – Ensure datasets are complete and timely

KLOE 1:

- Guidance published by NHS Digital in April 2022 sets out a framework for improving the quality of data submitted by providers to the Mental Health Services Dataset and Improving Access to Psychological Therapies (IAPT) Dataset. The guidance highlights that there is currently a lack of evidence about the impact of inequalities as they relate to mental health and that a focus on improving data quality is a crucial step towards tackling inequalities related to mental health, learning disabilities and autism. Improving the quality and completeness of our data will therefore continue to be a core workstream within the Trust’s approach to understanding and tackling inequalities.
- The Trust currently collects demographic data for all service users including home address, age, gender, ethnicity and any relevant physical or mental health diagnoses.

We have developed additional metrics which enable us to monitor the level of completeness of this key demographic data across our patient records. Prioritising the collection and completeness of this demographic data enables the Trust to monitor referrals, admissions and waiting times by protected characteristic and by other key indicators of inequality including deprivation decile, and internal dashboards have been developed to support this. The new Trust Dashboard currently in development will enable focused analysis of Trust activity by protected characteristic and can be developed over time to give us a comprehensive and up-to-date overview of inequalities related to Trust services.

- The Trust has delivered a series of awareness-raising sessions for staff across the organisation to increase understanding of the importance of collecting patients' demographic data and the benefits of doing this.
- Datasets are collected but not used routinely in decision-making. The data is being made more routinely available so it could be used in tackling health inequalities as part of the Trust group. A demo of the available data will be reviewed in the health inequalities group.
- Metrics related to data completeness are in place across the services and form part of the minimum dataset collected. The requirement for partners to collect Mental Health Services Data Set (MHSDS) data (where they are commissioned using MH funding), will be required to collect and submit certain demographic data to the national dataset.
- Patient-level data is included in various dashboards. Leadership requires more awareness training around using this data, what it means and how they can use it in day to day running of the service.

KLOE 2:

- The Trust's Inequalities Data and Evidence Group brings together analysts and public health expertise from the Trust and NEQOS to assess:
  - The data and evidence linked to inequalities currently available to the Trust.
  - Data and evidence which exists but isn't currently available to the Trust.
  - Gaps in data and evidence.
  - How we can develop the way we use data and evidence to inform action to address inequalities.
  - Initial areas of analysis for developing our understanding of inequalities at Trust level.
- Current areas of focus for the group include inequalities in access, experience and outcomes linked to Trust services and physical health inequalities among CNTW patients. A separate but linked group focuses on mortality. As this work progresses, actionable insights will be shared within the Trust to support the development of an evidence-based approach to tackling inequalities and monitoring the impact of our activities in this area.

KLOE 3:

- Workforce Race & Disability Equality Standard datasets complete.

- Equality Delivery System 2022 datasets complete.
- Action plans in place and priorities agreed by Trust Board.

KLOE 4:

- Managers have access to more data on demographic indicators, however, there needs to be more awareness raising that this data is available to them. The manager's training that is aimed at new managers on the importance of data and dashboards includes a section on reasons and the importance of collecting demographic data.

KLOE 5:

- Datasets not broken down for the majority of formal performance reports such as the integrated performance report. Datasets are able to be broken down for day-to-day performance reports by the locality. Staff will need some help to understand why they have access to this data and what it can be used for. The current dataset needs to be expanded on in future to include wider publicly available datasets.
- As part of the 2023/24 NHS contract, the Trust has an outlined health inequalities plan which includes two aspects of CORE20PLUS5 (Physical health checks for people with SMI and smoking cessation). A second action links to the Data Quality Improvement Plan (DQIP) which is about improving recording of indicators such as ethnicity. CNTW already has metrics related to data completeness and continues to monitor.

KLOE 6:

- Datasets are available but need to link to any internal plan related to health inequalities.
- Work is on-going with partners. We receive some data from primary care to inform staff of certain indicators e.g. disabilities. Our Electronic Patient Record (EPR) is not Spine compliant for staff to obtain data from primary care.
- The Trust's Inequalities Data and Evidence Group has established links with the NECS/ICB Director of Population Health and analysts at NECS who have been working with primary care data to understand physical health inequalities among people with SMI. A joint meeting is planned for November 2023 to share learning and identify how we might collaborate further. An initial discussion has also taken place about the Trust's potential involvement in NENC ICB's wider population health workstream.

KLOE 7:

- A meeting is taking place in November to further develop the Trustwide approach to health inequalities.
- Data is shared across some organisational boundaries e.g. with commissioners and Local Authorities. Work being undertaken by North of England Commissioning Support (NECS) on the use of MHSDS will allow us to obtain access to data from across the ICS for different providers. Work is ongoing to help other providers of Mental Health services to flow data to MHSDS so this will also be available in the shared dashboard. Where we are lead provider or lead commissioner, CNTW does obtain data from those we contract with.

- Once initial findings are developed based on analysis of existing inequalities data, we will engage with diverse local partners and communities to gather feedback which will enable us to understand and develop our data in the context of lived experience. Lived experience perspectives will be presented alongside the data to support decision-making at Trust level.

KLOE 8:

- A meeting is taking place in November to further develop the Trustwide approach to health inequalities.

Priority 4 – Proactively engage people at greatest risk in prevention

KLOE 1:

- Monthly Operational Integrated Performance Reporting:
    - Patients, quality, people, person-led care, sustainability
    - Assurances mapped against five Core Trust Integrated Outcome Measures, across 42 indicators (such as patient feedback, 18-week waits, urgent referrals seen, serious incidents, training compliance etc.)

KLOE 2:

- Physical Health Team – CNTW has a duty of care to all patients and overall responsibility to address and promote the wellbeing of its patients. All service users will receive a core assessment and a review of their physical health needs, and all service users admitted to hospital will receive a full physical health examination. The more common physical health conditions affecting patients in our care:
    - Covid-19
    - Diabetes
    - Epilepsy
    - Deteriorating physically ill patients – Early Warning Scores
    - Sepsis
    - Coronary Vascular Disease
    - Cancer
    - Podiatry
    - Naso Gastric Tube Feeding
- Physical and Public Health Policy – CNTW(C)29: The Trust promotes the provision of collaborative mental and physical health to ensure that all service users receive the right care, at the right time, in the most suitable health care environment. As stated by the Department of Health (2016), people with a mental illness should be offered the same physical health screening, monitoring and review as the general population, and where indicated, have any required interventions undertaken or be signposted to address any issues identified.

- Pregnancy and maternity considered within Physical Health Policy – contraception offered to service users to protect against pregnancy and STI transmission. A Practice Guidance Note is included for Safe Prescribing of Valproate, which particularly affects service users of childbearing age. The Screening Timeline within the policy covers pregnancy and maternity.
- Perinatal Community Mental Health Team provides a community service to support patients experiencing mental health difficulties related to pregnancy, childbirth and early parenthood. The Trust also works to minimise the risk of relapse in those women/patients who are currently well but who have a history of severe mental illness.
- All service users coming into inpatient wards are screened for physical health needs e.g. smoking status, alcohol use, long term conditions such as diabetes etc. If anyone smokes, a referral can be made to the QUIT team which supports patients admitted to CNTW who smoke, and patients with Nicotine addiction by offering behavioural support and ensuring patients have correct NRT/e cigarettes and are using these effectively.
- For patients on the Severe Mental Illness (SMI) Register, an annual health check is expected to be offered and completed by Primary Care in line with National policy.
- Annual flu / Covid-19 vaccination clinics are available for all staff and eligible inpatients.

KLOE 3:

- Locality community engagement – annual updates on links each Locality has within its local community and engagement undertaken.
- Health and wellbeing support available to CNTW workforce:
    - Thrive is CNTW's external health and wellbeing website, which is open to both staff and the public. The website is full of useful information and support for emotional health, physical health, benefits & discounts, career development and occupational health. Thrive includes access to resources on emotional, physical, psychological, social, and financial wellbeing
    - PAM Assist Occupational Health: provides a range of services designed to support and improve staff's overall health and wellbeing
    - Employee Assistance Programme (via Vivup): staff can access impartial, confidential advice from qualified counsellors
    - Staff Psychological Centre
    - Staff Networks
    - Staff Side and Trade Union support
    - Freedom To Speak Up Guardians and Champions

KLOE 5:

- Monthly Operational Integrated Performance Reporting:
    - Patients, quality, people, person-led care, sustainability

- › Assurances mapped against five Core Trust Integrated Outcome Measures, across 42 indicators (such as patient feedback, 18-week waits, urgent referrals seen, serious incidents, training compliance etc.)

KLOE 8:

- o Locality community engagement

Priority 5 – Strengthen leadership and accountability

KLOE 1:

- o Deputy CEO and Exec Medical Director sits on Board of ICB (collaborative working)
- o The People Committee (Board Sub-Committee) receives monthly updates from the Equality, Diversity & Inclusion Steering Group and feeds updates through to monthly Trust Board meetings.
- o The Patient and Carer Race Equality Framework (PCREF) is a mandatory anti-racism framework for mental health Trusts and providers in England. All mental health Trusts must have their PCREF in place by the end of the financial year 2024/25, and each Trust's PCREF must be fully co-produced with local racialised and ethnically and culturally diverse communities.
- o Mental health providers are responsible for the delivery of PCREF in collaboration with partners including local authorities, commissioners, communities, patients, and carers. PCREF will see mental health Trusts become actively anti-racist organisations by reducing racial inequalities within their services. The framework applies to all mental health services and pathways and all patient age cohorts.
- o PCREF implementation will cut across all 8 KLOEs highlighted in this paper and will require strong leadership at both Trust and system level as well as robust governance and community participation to ensure accountability. Following the national launch of PCREF in November 2023 the Trust is currently preparing for phase 1 of this work i.e. the development and publication of CNTW's PCREF by March 2025. We are developing an implementation plan for this phase of the work and conducting an analysis of existing Trust initiatives which support the elimination of racial inequalities. Further updates will be provided as this work progresses.

KLOE 2:

- o Strategy 'With you in mind' ensures staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these.
- o The People Committee (Board Sub-Committee) receives monthly updates from the Equality, Diversity & Inclusion Steering Group and feeds updates through to monthly Trust Board meetings.
- o Board and senior-level meeting papers include 'risks identified' section.
- o Quality Account / Quality Priorities – EDI has been part of the Quality Account for the past three years and is reported on Quarterly.

- Gender Pay Gap is discussed at Board each year.
- Equality, Diversity Inclusion & Human Rights Annual Report is received by Board each year.
- Workforce Race and Disability Equality Standard findings and action plan is presented and agreed at Trust Board each year.

KLOE 3:

- Organisational culture comes from staff and leadership:
    - Equality, Diversity & Inclusion training available (LGBTQ+ / menopause / Learning Disability / Autism etc.)
    - LGBT policy (Sophie Robinson / Chris Rowlands)
    - Cultural competence package / resources in development
    - Respectful Resolution Framework.
    - Cultural Celebration Events embedded across Trust.
- Exec SRO – Lynne Shaw

KLOE 4:

- 'With you in mind' strategy – staff inclusively involved in shaping vision, strategy, and delivery plans.
- Operational issues routinely discussed at Board level (Integrated Performance Reports etc.)

KLOE 5:

- Reports publicly shared on website / intranet
- The People Committee (Board Sub-Committee) receives monthly updates from the Equality, Diversity & Inclusion Steering Group and feeds updates through to Trust Board meetings.
- Board and senior-level meeting papers include 'risks identified' section.
- Quality Account / Quality Priorities – EDI has been part of the Quality Account for the past three years and is reported on Quarterly.
- Gender Pay Gap is discussed at Board each year.
- Equality, Diversity Inclusion & Human Rights Annual Report is received by Board each year.
- Workforce Race and Disability Equality Standard findings and action plan is presented and priorities agreed at Trust Board each year.

KLOE 7:

- Locality community engagement
- Service User Carer Reference forum – leadership attendance

- Exec Q&As
- Exec site visits

KLOE 8:

- Board level listening to feedback, service user and staff stories at board, Exec and NED service visits etc.
- Champion learning & innovation:
  - Academy – CNTW Academy has responsibility for Learning and Development across the Trust. It covers everything from essential and statutory training, advanced clinical practice and basic numeracy and literacy through to in-house bespoke accredited courses. We offer several strands of personal development and career pathway progression and provide access to a range of educational opportunities for all staff groups including a number of apprenticeship opportunities such as the Nursing Degree Apprenticeships or Management Development. The Academy is made up of a dedicated team of Nurses, AHP's and Administrators whose aim is to serve the needs of the organisation.
  - Trust Innovation – CNTW's improvement service, helping people and organisations continuously improve the quality of the services they provide. Trust Innovation works together with the Safety, Security & Resilience Team to ensure the best outcomes for our staff and people who use our services.

12. ANNUAL DEANERY REPORT

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

REFERENCES

Only PDFs are attached

12. Annual Deanery Report.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6th December 2023
Title of report	NHS England – Workforce, Training and Education (WTE) Directorate, Annual Quality Report 2023
Executive Lead	Dr Rajesh Nadkarni, Medical Director / Deputy Chief Executive
Report author	NHS England

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

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

NHS England - Workforce, Training and Education (WTE) Directorate

Annual Quality Report 2023

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

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1 Background to this Annual Report

The 2023 Annual Education and Training Quality Report from NHS England Workforce Training and Education Directorate of North East and North Cumbria (NHSE-WTE NENC) is the successor to similar previous reports provided by Health Education England North East & North Cumbria (HEE NE) following HEE's incorporation into NHS England earlier in 2023.

The Annual Report provides a summary of the education and training provided by the named Local Education Provider (LEP) over the course of the full 2022-23 training cycle (August 2022-July 2023) and its purpose is to promote a board level overview of the training related strengths and weaknesses of the LEP including the associated financial governance of monies provided through the NHS Education Contract.

The report also details priorities for action over the 2023-24 training cycle and associated NHSE-WTE offers of support. Further detail supporting this report is contained in the LEP's own Self-Assessment Report (SAR) as submitted to HEE NE in January 2023 and also in the LEP's ongoing Quality Improvement Plan (QIP). The end of year position detailed in the attached overview grid was confirmed with the LEP's senior leadership attendees at the 2023 HEE NE Annual Dean's Quality Meeting (ADQM).

NHSE-WTE role in the Quality Management and Assurance of the Clinical Learning Environment

As with its predecessor HEE, NHSE-WTE is responsible for monitoring and providing onward assurance to NHS England, the system and professional regulators, and the wider NHS regarding the quality of the clinical learning environment of all approved clinical training and education placements.

The Postgraduate Dean (PGD) has overall responsibility to ensure the quality of all placements and the required standards are contained in the six themes of the HEE Quality Framework (HEE-QF) and the associated escalations of the HEE Intensive Support Framework (HEE- ISF) which continue to apply. In addition, for all medical training programmes the GMC Standards for Training (Promoting Excellence) also apply.

NHSE-WTE works with and provides support to each LEP throughout every training cycle and provides significant amounts of funding to each organisation through the NHS Education Contract in order to support the clinical placements, the trainers and educators employed by the LEP, as well as to support the provision of education and training related resources and facilities within the LEP.

NHSE-WTE gains assurance through the scheduled programme-led monitoring of training placements including Quality Reporting, Visits, and Meetings, and through triangulation of data and information it shares with and receives from programmes managed at a regional or national level (e.g. Libraries, Pharmacy, Healthcare Science), and with other organisations including Higher Education Institutions (HEIs), other NHS bodies and the system regulators including the Care Quality Commission (CQC) and the professional regulators.

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NHSE-WTE continues to use the escalation processes of the HEE-ISF to describe and monitor any concerns identified, and it describes concerns based on the level at which it is having to work with any individual organisation, department, programme, or the wider system to ensure consistency in the way that concerns are identified, described, and shared, and also to ensure the appropriate steps are taken to clarify, improve and resolve the concerns raised.

When there are concerns that a LEP is failing to meet required HEE or regulator standards, either as a whole organisation, in individual training departments, or when there is system-wide concern about an organisation, NHSE-WTE works directly with the wider NHS via the System Quality Group (SQG) led by the Integrated Care Board (ICB), and through NHSE Quality Improvement Boards and Risk Summits to discuss the issues of concern, to confirm and agree plans for improvement with the LEP, and to agree outcome measures of success with a realistic timeframe for these to be achieved.

As with its predecessor HEE, NHSE-WTE remains keen to provide support to improve training and education in all locations. Should programme-level actions fail to resolve issues then the relevant NHSE-WTE Deputy Postgraduate Deans/Directors responsible the Foundation, Specialty, and General Practice training programmes and the Director for Quality and Revalidation are available for are available for consultation, advice and to coordinate further actions as deemed necessary, as are the Postgraduate Dean and the Postgraduate Dental Dean. All will work with the LEP at Director and Board Level to help resolve issues and concerns.

The statutory responsibilities of the Postgraduate Dean across NENC

It is important to note that all the longstanding statutory duties and responsibilities of the Postgraduate Dean continue to apply and that, in addition to their management role within NHS England, the PGD also has separate statutory accountability to the General Medical Council for assuring the quality of all medical training placements for ongoing approval, for the delivery of all approved training programmes, and for being the Responsible Officer (RO) for the designated body NHS England Education North East for revalidation purposes.

Please note that the Postgraduate Dean is therefore the Responsible Officer for ALL doctors training in approved training placements across the North East and North Cumbria. In addition to overseeing the revalidation processes for all doctors in training, should any revalidation or fitness to practice concerns arise concerning any doctor in training then, as that doctor’s RO, the Postgraduate Dean must be informed as soon as possible via direct contact and the locally agreed Live Flow processes and the PGD must also lead any fitness to practice decision- making processes.

The PGD is also available for RO to RO communications as described by the GMC revalidation processes.

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Employment of Postgraduate Doctors in Training across NENC by the Lead Employer Trust

Similarly, for ALL doctors training in approved training placements across the North East and North Cumbria the Lead Employer Trust (LET) is each individual doctor's employer and manages both their contract of employment and any Maintaining High Professional Standards (MHPS) concerns that may arise. The LET must therefore be informed of any concerns relating to the conduct and health of individual doctors in training using the agreed processes including Revalidation Live Flow.

The LET therefore works very closely with the PGD and their deputies but it is important to note that the LET and WTE-NENC are separate organisations with the LET being responsible for the management of the employment of all trainees across NENC and with the PGD being responsible for the revalidation of all trainees as well as for the quality and provision of all the approved postgraduate medical training programmes and placements.

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2 Executive Overview and NE WTE statement of Assurance

NHS England Workforce Training and Education works with all Local Education Providers via its Training Programmes and Directorates and uses the levels of the HEE Intensive Support Framework (HEE-ISF) to describe Quality in terms of the level of activity at which it is having to work with each LEP and Programme and with the wider system for any given issue The table below gives the NHSE-WTE year-end high-level overview of your organisation by ISF level as of the end of July 2023. A broader service level overview is provided in the grid in Appendix 1.

All ISF levels and the underlying reasons for any escalation were discussed at each LEP's 2023 ADQM and all escalated issues are outlined at the end of this section. NHSE-WTE and the GMC are made aware of any escalations at ISF1 and above and the wider system is aware of escalations at ISF2 and above.

With the exception of any escalated issues identified below, NHSE-WTE is currently assured of the quality of education and training provided by Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust and also with the organisational levels of engagement and support provided over the past training year. It is important to note that the quality management of education and training is a live process and that any concerns or escalations arising after the end of July 2023 will be communicated separately as part of the 2023-24 training cycle.

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust WTE NENC Summary View of LEP for Training Cycle August 2022 to July 2023							
Initial Education Contract (LDA) WTE NE Funding 2022-23: £14,683,618							
Current WTE Intensive Support Framework Escalation Levels							
	Overall	Domain 1 Learning Environment & Culture	Domain 2 Educational Governance & Leadership	Domain 3 Supporting & Empowering Learners	Domain 4 Supporting & Empowering Educators	Domain 5 Delivering Curricula & Assessments	Domain 6 Developing a Sustainable Workforce
WTE ISF LEVEL	0	0	0	0*	0*	0	0

WTE ISF Escalation Level Key: PGD Oversight using WTE NENC Quality Meeting (DEMQ) & WTE NENC Quality Processes	
	0* - Programme Level Management
	0 - Programme Level Management
	1 - Directorate Level Management
	2 - System Level Notification
	3 - High Risk of Training Suspension
	4 - Training Suspended

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Summary of current training issues escalated to ISF Level 1 and above

ISF Level 1 – Specialty Directorate	Child and Adolescent Mental Health Services

CAMHS remains a fragile clinical service particularly regarding inpatient provision and CNTW now provides this service in the Tees Valley area. The Specialty Directorate will continue to monitor and work with you to ensure training placements and curriculum requirements are being delivered.

Summary of 2022-23 LEP Quality Reporting and Senior Leadership Engagement including ADQM

NHSE-WTE thanks Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust for its hard work and engagement in ensuring that the North East and North Cumbria collectively continues to deliver the highest rated training in the UK. This commitment to work together has been maintained through the most challenging years in NHS history and is a credit to all concerned from the clinical 'shop floor' to those giving oversight and support to education and training from Board level.

This year the Annual Dean's Quality Meeting was held face-to-face and was attended by those holding educational leadership roles across a wide range of clinical professions as well as by members of the trust board. This continuing high-level engagement is appreciated, and it allowed open discussion of the LEP's wider strategies to support education and training and the wellbeing of all staff. Discussions about any issues of concern were held including confirmation of any level of escalation together with a commitment given by both the LEP and NHSE-WTE to work together to resolve issues over the current 2023-24 training cycle.

In addition to quality reporting, discussions were held around the formal contracting and finance of education and training within the LEP including the new NHS Educational Contract and including the LEPs current use of monies provided by NHSE-WTE to ensure the support of trainees and learners and those providing them with educational supervision. Discussions were specifically held with the Lead Employer Trust regarding the Junior Doctors Contract and Exception Reporting.

Ongoing post-pandemic recovery plans were also discussed including the workforce needed by the LEP to provide current and future clinical services and to maintain appropriate levels of educational and clinical supervision with adequate curricular experience for both postgraduate trainees and undergraduate students. The need for rapid decision making and financial commitment to support new posts in shortage areas when opportunities arise was stressed as national opportunities to expand training programmes can occur unpredictably and often with short periods of notice to commit to long term workforce expansion.

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The 2023 ADQM also provided an opportunity to discuss wider LEP strategies including ensuring the safety, health and wellbeing of all staff, their ability to raise concerns for clinical, educational, and professional issues, and the LEP's strategies for promoting Equality, Diversity, and Inclusion.

In 2024 ADQMs will once again be held with each LEP in the Spring/Summer and your organisation will be contacted with good notice to arrange a mutually suitable date for the meeting.

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3 Plans for 2023-24 Quality Reporting including LEP Self-Assessment Report

The templates for 2023-24 Quality Reporting including the LEP Self-Assessment Report and Quality Improvement Plan have been sent to your organisation. The overall core structure of the SAR and your Board Level declaration that all the relevant training and education standards are being met has not changed and reporting to both the WTE Multi-professional Quality Framework and GMC Promoting Excellence for both Postgraduate Medical Training and Undergraduate Medical Education will continue as in previous years. For 2023-24 there are appendices for reporting and commenting on the WTE Equality, Diversity, and Inclusion, Simulation and Human factors and Supporting Return to Training. The appendices are set out to collate opinion from all LEPs, with an aim to facilitate local and collaborative ways of working.

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4 2023-24 Quality Cycle – Reporting Timeline and Significant Events

To facilitate planning of quality reporting and meetings in 2023-24, the table below summarises key dates and events from September 2023 onwards. Please note that the WTE NE Quality Team can always be contacted via Quality.NE@WTE.nhs.uk

Analysis of 2023 GMC NTS Trainee & Trainer Surveys	September 2023
WTE NENC to send 2023/24 Annual Report Documents (SAR/QIP) and updated Guidance to LEPs	September 2023
Trusts to submit updated QIP to the Quality Team	30 September 2023
Quality Team offer of support engagement meetings to Trusts	November 2023 - January 2024
National Education and Training Survey (NETS) open	October 2023
Trusts to return completed 2022/23 Annual Report (SAR/QIP/Unit reports) to the Quality Team	29 February 2024
WTE NE to arrange dates with LEPs for 2023 ADQMs	From November 2023
Anticipated dates for 2023 GMC NTS Trainee & Trainer Surveys	April - May 2024
2023 Annual Dean's Quality Meetings (ADQMs) with Trusts	May - July 2024
Quality Team to send 2022/23 End of Year Trust Reports and Grids to LEPs	September 2024

On behalf of HEE North East & North Cumbria October 2023

Namita Kumar

Professor Namita Kumar

WTE NE Postgraduate Dean

Mr Pete Blakeman

Deputy Postgraduate Dean & Quality Director

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Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

Last HEE review	Aug-23
Last LEP review	

LEP

Quality Information

£14,683,618

HEE Overall ISF Level	
0	
CQC Current View	Rating July 2018

Regulator/System Ratings

CQC Domains	CQC Ratings
Safe	G
Effective	O
Caring	O
Responsive	O
Well Led	O

NHSI Segment Rating	SQG Monitoring
1	Routine

National Survey Data

Date	GMC NTS Trainee	GMC NTS Trainer	HEE NETS
	Jul-22	Jul-22	Nov-22
UK Rank	33/236	11/221	
HEE Rank	30/208	10/201	36/211

HEE Current View

	CQC Current View	1 Learning Environment & Culture	2 Educational Governance & Leadership	3 Supporting & Empowering Learners	4 Supporting & Empowering Educators	5 Delivering Curricula & Assessments	6 Developing a Sustainable Workforce	Positives	Negatives
Trust Overall	Outstanding	0	0	0*	0*	0	0	2: Year on year ranking in trainee NTS 3: Year on year ranking in trainee NTS 4: Year on year ranking in trainer NTS	
Adults of Working Age	Good	0	0	0	0*	0	0	F1 Psychiatry 1, 2 Trainers 1,4,5	
Child & Adolescent	Outstanding	0	1	0	0*	1	1	2: consecutive CSOOH 3: consecutitve RT	CAMHS (Lotus formerly West Lane) Theme 2,5
Community	Outstanding	0	0	0	0	0	0		
Older People	Good	0	0	0	0*	0	0	Trainers 1,4,5	3: LT RT Post LT RT
Forensic	Good	0	0	0	0	0	0		
Rehabilitation	Outstanding	0	0	0	0	0	0	1:Post RD,SE,T,WL 2: Post CSOOH, I, RS	
Learning Disability	Requires Improvement	0	0	0	0	0	0	2: Post EG, I 3: Post F,RT Post consecutive RT	

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13. SUB-COMMITTEES TERMS OF REFERENCE

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

13. Board and Committee Annual Review 2023.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6th December 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	
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		Management meetings where this item has been considered	
Quality and Performance	x	Executive Team	
Audit	x	Executive Management Group	
Mental Health Legislation	x	Business Delivery Group	
Remuneration Committee	x	Trust Safety Group	
Resource and Business Assurance	x	Locality Operational Management Group	
Charitable Funds Committee	x		
People	x		
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	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 reviewed by the Board at the November meeting.

Following a query raised in relation to Committee membership, the following changes have been made.

	Committee	Change Since last approval
1	Board of Directors	No changes proposed.
2	Resource and Business Assurance	Locality representation confirmed as Locality Group Director Governor representation in attendance.
3	Quality and Performance	Locality representation confirmed as Locality Group Director, Locality Group Nurse Director and Locality Group Medical Director. Governor representation in attendance.
4	Mental Health Legislation	Locality representation confirmed as Locality Group Medical Director Governor representation in attendance.
5	Audit	No changes proposed.
6	Provider Collaborative and Lead Provider	Governor representation in attendance.
7	People	Locality representation confirmed as Locality Group Nurse Director Governor representation in attendance
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
December 2023

1. Board of Directors
Terms of Reference

Name	Board of Directors
Timing & Frequency	Board meetings will be held quarterly in public. Closed Board meetings will be held 8 times per year.
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

Leadership

- 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

Culture, Ethics and Integrity

- 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: December 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
In Attendance	Director of Communications and Corporate Affairs Matthew Lessell, Director of Estates, NTW Solutions Ltd Governor representative x 2
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: December 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 Deputy Chief Operating Officer Deputy Director of Nursing Director of AHPs and Psychological Services Chief Pharmacist 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 Governor representatives x 2
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: December 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 Medical Director representative Group Medical Director (Chair of the Mental Health Legislation Steering Group)
In Attendance	Director of Communications and Corporate Affairs Representatives of Mental Health Legislation Team Governor Representatives x 2
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: December 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 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 Governor representatives x 2
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: December 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 Nurse Director
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 Governor representatives x 2
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: December 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: December 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

14. INTEGRATED CARE SYSTEM / INTEGRATED CARE BOARD UPDATE

James Duncan, Chief Executive

verbal update

15. FINANCE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

15. 2324 - Board - Mth 7 Finance Board - Public.pdf

Name of meeting	Board of Directors Public Meeting
Date of Meeting	Wednesday 6th December 2023
Title of report	Month 7 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		Management meetings where this item has been considered	
Quality and Performance		Executive Team	x
Audit		Business Delivery Group	x
Mental Health Legislation		Trust Safety Group	
Remuneration Committee		Locality Operational Management Group	
Resource and Business Assurance	X	Executive Management Group	x
Charitable Funds Committee			
Provider Collaborative/Lead Provider			
People			
Provider Collaborative			
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	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

Board of Directors Meeting

Wednesday 6th December 2023

Month 7 Finance Report

1. Executive Summary

1.1 A **The Trust has generated a £5.4m deficit year to date**. This includes a benefit from the land sale at Northgate of £5.8m. 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 Month 7**. 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 again in Month 7. 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 7 the Trust has spent £10.2m (cumulative) on agency staff against a plan £9.8m and the Trusts nationally applied agency ceiling of £8.4m. The Trust is currently forecasting to reduce monthly agency expenditure to below the agency cap levels in Quarter 4 this year.

1.4 **Expenditure on the Trust capital programme is £2.5m lower than planned** at Month 7. 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 £32.3m** at the end of Month 7 which remains ahead of plan but has again reduced since last month.

2. Key Financial Targets

2.1 Table 1 highlights the key financial metrics for Month 7.

Table 1

	Month 7		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit)	(£5.6m)	(£5.4m)	(£0.2m)
Agency Spend	£9.8m	£10.2m	£0.4m
Cash	£20.4m	£32.3m	(£11.9m)
Capital Spend	£6.9m	£4.4m	£2.5m

3. Financial Performance

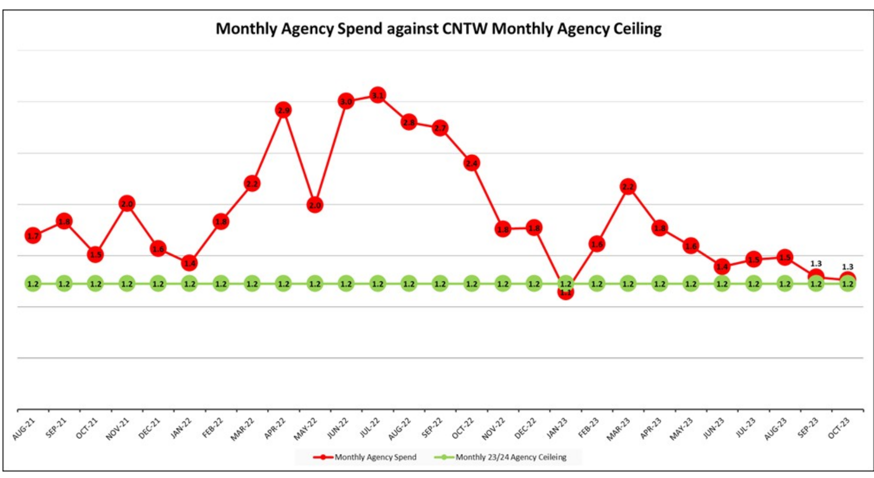
Income and Expenditure

3.1 At the end of Month 7 the Trust has reported a £5.4m 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 reducing despite the Trust managing to the I&E forecast.

3.2 The Trust has a more ambitiously phased internal plan for CIP delivery and is currently managing to this trajectory internally.

3.3 Graph 1 below highlights the agency performance from August 2021. Costs in August stand at c£1.3m. Costs remain above the Trust budget year to date, but is below the monthly budgeted level of £1.4m. 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 1



3.4 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.

3.5 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.

3.6 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 within the organisation. WTEs have fallen slightly this month, reducing pay cost pressure within the organisation.

Table 2

	WTE Oct 22	WTE Sept 24	WTE Oct 24	Change Since Last month	Change in 24 Mth
Substantive	7,321	8,166	8,227	61.5	906.3
Bank	315	307	291	(15.8)	(23.9)
Agency	366	305	226	(78.4)	(139.5)
	8,002	**8,777**	**8,745**	**(32.7)**	**742.9**

4. Cash

Table 3

	Year To Date		
	Plan (£m)	Actual (£m)	Variance/ Rating (£m)
Cash	20.4	32.3	(11.9)

4.1 Cash balances at the end of September were £11.9m higher than plan, but have reduced in Month 7.

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	6.9	4.4	(2.5)	20.8	18.9	(1.9)
Asset Sales	0.0	0.0	(0.0)	6.5	6.4	(0.1)

5.1 The Trust Capital spend at the end of Month 7 is £4.4m which is £2.5m 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.

5.2 The Trust capital programme includes an assumption of additional PDC funding for the CEDAR programme, as outlined above. This has been part of ongoing discussions with the New Hospitals Programme. The Trust has provided a revised Business Case in line with expectations and timescales outlined by the New Hospitals Programme (NHP). This has been considered by the NHP investment committee, who supported the case to proceed to the NHSE for approval. NHSE have also approved the case and it is now with Treasury for final approval.

6. Expenditure controls

6.1 The Trust board and Resources and Business Assurance Committee received updates in Month 6 on the application of the expenditure controls as directed by the NHSE Regional Director. The update has been shared with the ICB, who are currently liaising with NHSE at system level (due to the ICS reporting a deficit position overall). This liaison is ongoing; however, Trusts may be asked to demonstrate compliance with the checklist beyond that currently provided. This is an emerging issue with no formal requests currently received. Updates will be provided to the Board as and when they become available.

7. H2 funding

7.1 The Board of Directors were briefed on the arrangements for additional funding for funding for Months 7-12 23/24. Agreement from Board members was reached electronically to reconfirm the Trust will meet the 23/24 financial plan and breakeven.

8. Recommendations

8.1 The Board is asked to note the content of this report.

16. QUALITY AND PERFORMANCE COMMITTEE

Louise Nelson, Chair

No meetings held during the period

17. AUDIT COMMITTEE

David Arthur, Chair

No meetings held during the period

18. RESOURCE AND BUSINESS ASSURANCE COMMITTEE

Paula Breen, Chair

No meetings held during the period

19. MENTAL HEALTH LEGISLATION COMMITTEE

Michael Robinson, Chair

No meetings held during the period

20. PROVIDER COLLABORATIVE COMMITTEE

Michael Robinson, Chair

No meetings held during the period

21. PEOPLE COMMITTEE

Brendan Hill, Chair

No meetings held during the period

22. CHARITABLE FUNDS COMMITTEE

Louise Nelson, Chair

No meetings held during the period

23. COUNCIL OF GOVERNORS' ISSUES

Darren Best, Chairman

24. QUESTIONS FROM THE PUBLIC

Darren Best, Chairman

25. ANY OTHER BUSINESS

Darren Best, Chairman

26. DATE AND TIME OF NEXT MEETING

Wednesday 7th February 2024
1:30 - 3:30pm
Trust Board Room, St Nicholas Hospital and Microsoft Teams