Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

5 June 2024

13:30 GMT+1 Europe/London

Trust Board Room and via YouTube

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Public Board will now be live-streamed via You Tube and will not be available via a Microsoft Teams application.

To listen to the Board meeting please copy and paste the following link into your web browser or alternatively click to view https://www.youtube.com/@cntw

AGENDA

1. STANDING AGENDA ITEMS

Darren Best, Chair

REFERENCES

Only PDFs are attached

Board FINAL agenda Public JUNE 24.pdf

Board of Directors Board Meeting held in Public Agenda

Board of Directors Board meeting held in public **Venue: Trust Board Room, St Nicholas Hospital IN PERSON ONLY** **This meeting will be live-streamed**	**Date: 5 June 2024** **Time: 1:30pm – 3.30pm**

	Item	Lead	
	Standing agenda items		
1.1	Welcome and Apologies for Absence	Darren Best, Chair	Verbal
1.2	Declaration of Interest	Darren Best, Chair	Verbal
1.3	Minutes of the meeting held 6 March 2024	Darren Best, Chair	Enc
1.4	Action Log and Matters Arising from previous meeting	Darren Best, Chair	Enc
2. Strategic Ambition 1 – Quality care, every day			
2.1	Quality and Performance Committee Assurance Report (for assurance)	Louise Nelson, Committee Chair	Enc
2.2	Mental Health Legislation Committee Assurance Report (for assurance)	Michael Robinson, Committee Chair	Enc
2.3	Integrated Performance Report – Quality care, every day (for assurance)	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance and Rajesh Nadkarni, Deputy Chief Executive / Medical Director	Enc
3. Strategic Ambition 2 – Person led care, where and when it's needed			
3.2	Integrated Performance Report – Person led care, when and where it's needed (for assurance)	Ramona Duguid, Chief Operating Officer	Enc

4. Strategic Ambition 3 – a great place to work			
4.1	People Committee Assurance Report (for assurance)	Brendan Hill, Committee Chair	Enc
4.2	Safer Staffing Report exception report (for assurance)	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc
4.3	Equality, Diversity and Inclusion Report (for assurance)	Lynne Shaw, Executive Director of Workforce and OD	Enc
4.4	Raising Concerns Report (for assurance)	Lynne Shaw, Executive Director of Workforce and OD	Enc
4.5	Staff Survey 2023 Report (for assurance)	Lynne Shaw, Executive Director of Workforce and OD	Enc
4.6	Integrated Performance Report – A great place to work (for assurance)	Lynne Shaw, Executive Director of Workforce and OD	Enc
5. Strategic Ambition 4 – sustainable for the long term, innovating every day			
5.1	Finance Report (for assurance)	Kevin Scollay, Executive Director of Finance	Enc
5.2	Annual Plan and Priorities **(for approval)**	Kevin Scollay, Executive Director of Finance	Enc
5.3	Integrated Performance Report – Sustainable for the long term, innovating every day (for assurance)	Kevin Scollay, Executive Director of Finance	Enc
5.4	Resource and Business Assurance Committee Report (for assurance)	Paula Breen, Committee Chair	Enc
6. Strategic Ambition 5 – working for, and with our communities			
6.1	System working report / policy updates (for information)	James Duncan, Chief Executive	Enc

6.2	Charitable Funds Assurance Committee (for assurance)	Louise Nelson, Committee Chair	Enc
7. Governance and Regulatory			
7.1	Audit Committee Assurance Report (for assurance)	David Arthur, Committee Chair	Enc
7.2	Fit and proper persons / declaration of interest annual review **(for approval)**	Lynne Shaw, Executive Director of Workforce and OD	Enc
7.3	Modern Slavery Statement **(for approval)**	James Duncan, Chief Executive	Enc
7.4	Board Committee Terms of Reference **(for approval)**		
	7.4.1 Quality and Performance Committee	Louise Nelson, Committee Chair	Enc
	7.4.2 People Committee	Brendan Hill, Committee Chair	Enc
	7.4.3 Audit Committee	David Arthur, Committee Chair	Enc
7.5	Board Assurance Framework / Corporate Risk Register report	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc
8. Any other business / items for information			
8.1	Chair's Report (for information)	Darren Best, Chair	Enc
8.2	Chief Executive report (for information)	James Duncan, Chief Executive	Enc
8.3	Questions from Governors and the public	Darren Best, Chair	

Date of next meeting
4th September 2024, St Nicholas Hospital Board Room and via YouTube

1.1 WELCOME AND APOLOGIES FOR ABSENCE

Darren Best, Chair

1.2 DECLARATION OF INTEREST

Darren Best, Chair

1.3 MINUTES OF THE MEETING HELD 6TH MARCH 2024

Darren Best, Chair

REFERENCES

Only PDFs are attached

1.3 Public Minutes 6 March 2024 DRAFT FINAL CHECK.pdf

Minutes of the Board of Directors meeting held in Public
Wednesday 6 March 2024 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 (online)
Brendan Hill, Vice-Chair/Non-Executive Director
Michael Robinson, Non-Executive Director
Louise Nelson, Non-Executive Director
Vikas Kumar, Non-Executive Director
Rachel Bourne, 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)
Anne Carlile, Lead Governor and Carer Governor, Adult Services
Wendy Pattison, Local Authority Governor, Northumberland Council
Ruth Berkely, Local Authority Governor, South Tyneside Council
Siobhan Watson, Non-Clinical Staff Governor
Thomas Lewis, Medical Staff Governor
Doreen Chananda, Clinical Staff Governor
Amber Cormack, Clinical Staff Governor
Star Ncube, Northumbria University Governor
Russell Bowman, Service User, Neuro-disability Services
Russell Stronach, Service User, Autism Services
William Miskelly, Public Governor, Cumbria
Two members of the public were in attendance

STANDING AGENDA ITEMS

1.1 Welcome and apologies for absence

Darren Best welcomed everyone to the first public board meeting of 2024 and introductions were made from board members. There were no apologies for absence received.

Darren highlighted the organisations commitment to openness and transparency and the importance of public accountability. Therefore, from June 2024, Board members held in public will be live streamed. Information on how to access meetings will be available on the Trust website.

Darren referred to the new approach to agenda planning which is now structured in accordance with the Trust's strategic ambitions outlined in the Trust's Strategy, 'With you in mind'.

1.2 Declarations of interest

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

1.3 Minutes of the meeting held 6 December 2023

The minutes of the meeting held on 6 December 2023 were considered and agreed.

Approved:

- **The minutes of the meetings held 6 December were approved.**

1.4 Action log and matters arising not included on the agenda

Item 05.07.2023 (7) Public Policy Research Health and Care Workforce Assembly Report:
Brendan Hill referred to the Chief Executive Report from July 2023, that highlighted new and changing roles within workforce and suggested that in the context of the Trust's discussions and development on workforce planning, this action be addressed and overseen by the People Committee. This was agreed and the action will be removed from the action log.

1.5 Chairman's update

Darren welcomed Rachel Bourne and Vikas Kumar as two new Non-Executive Directors after a successful appointment process overseen by the Governors' Nomination Committee. The interview process also identified a third candidate, Robin Earl who was successfully appointed as Non-Executive Director, to replace David Arthur when he steps down from his role as NED and Audit Committee Chair in January 2025. Robin will join the Board in July 2024, allowing a period of handover with David.

Darren referred to discussions with both the Board of Directors and Council of Governors on plans to develop ongoing programmes of training and development for the coming year. This will further enhance the work of the Board, Board committees, and Council by ensuring a clear focus on our ability to hold, and be held, to account, and using time wisely to focus on the key issues facing the Trust.

Over the coming months, members of the Board will be undertaking their individual annual appraisal process spending time reflecting on the past year and discussing individual and collective objectives. This will include a particular focus for all Board members on equality, diversity and inclusion and will be underpinned by the new national Leadership and Competency Framework.

Darren referred to key challenges in the context of the Trust strategy, how we deliver our strategic ambitions and commitments, service change in terms of our model of care and support, supporting our workforce, organisational culture, and sustainability. The new Board agenda structure will enable a clearer focus on progress to deliver these ambitions. Darren highlighted the importance of listening to, and genuinely hearing the voices of service users and carers to challenge and inform our development and plans for services.

Darren referred to the summary of recent meetings and visits undertaken during the period and thanked Russell Bowman, Service User Governor, who attended a visit to Walkergate Park along with James Duncan. Undertaking the visit with Russell, who has lived experience of receiving services contributed to the value of the visit. Non-Executive Directors as well as Governors are about to embark their programme of service visits for 2024.

The report highlights the importance of Equality, Diversity, and Inclusion in the workplace. 1 March celebrated Zero Discrimination Day and Darren spoke about the Trust's Give Respect, Get Respect campaign and the importance of people feeling like they have a voice, to use that voice to give feedback, to help the organisation be better, and to provide the best services we can to individuals and communities.

Darren explained as part of the Chairs role, it is important to remain connected to the local and national agenda by meeting key individuals and forums for mutual benefit and the report provides detail of the key themes from discussions.

Resolved:

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

1.6 Chief Executive's Report

James Duncan referred to the report highlighting two conferences taking place recently. CNTW Research and Innovation conference with involvement in research, now acknowledged as a key marker of quality in healthcare. The new Community Recovery and Wellbeing Hubs run by CNTW in partnership with Carlisle Matters and other local organisations launched in January 2024 in Workington and Carlisle. James referred to the community transformation work and the importance of changing the way we deliver services across communities.

This week James will be visiting The Space in Newcastle, a groundbreaking wellbeing support hub will include professionals from multiple services. The hub has been developed in partnership with organisations including CNTW, West End Family Health Primary Care Network, Everyturn, Changing Lives, Re-co-co, Newcastle University, Newcastle Council, VITA talking therapies and James' Place Newcastle.

James noted the five key areas of action to support hospital discharge for people with a learning disability and autistic people which is also a key priority across the North East and North Cumbria Integrated Care System (NENC ICS).

Michael Robinson referred to a service visit he attended which discussed arts therapy for people with early onset dementia and queried if this would be covered within the Art Therapy / Art Psychotherapy apprenticeship. James acknowledged that this is the first apprenticeship of its kind in the country and advised that it will allow us to expand the choice of therapies we are able to offer people who access our services across different teams within the organisation.

Vikas Kumar commented how art therapy can help improve mental health and wellbeing and commended the development of the apprenticeship programme. He suggested it would be a good opportunity to connect with the National Centre for Creative Health and the All-Party Parliamentary Group on Arts which launched a report on the Creative Health Review in December 2023.

Vikas queried if the work ongoing within the Farsi communities will continue after March 2024. Rajesh Nadkarni stated that plans are in place to create videos to highlight the impact of the work to date with a view to promoting this into other areas. Vikas explained this type of work would be beneficial for those who are suffering forced migration and seeking asylum where mental health and wellbeing may be a considerable issue in terms of how and where they access services.

Resolved:

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

1.7 Integrated Performance Report (Month 10)

Ramona Duguid referred to the report noting that there were no inappropriate out of area placement reflecting a sustained improvement.

Ramona noted improvement in the 4-week waiting time for working age adults and older people however the Trust remains significantly challenged around children and young people waits. Progress has been made internally in terms of the pathway review work and moving to standardisation across each of the localities. There is also a clear recommendation to NENC ICB colleagues to ensuring the focus continues including focussing on early access support.

Ramona referred to the Psychiatric Liaison Team (PLT) crisis position and the work undertaken to move to an improved position. Challenges remain in Crisis services, particularly in the context of some of the system-changes for example, implementation of Right Care, Right Person, move to NHS 111, as well as local issues including ongoing capacity challenges across Crisis services and the need to ensure links into the community transformation work. Ramona advised that the Quality and Performance Committee will receive an exception report at a future meeting.

Rajesh Nadkarni noted that incidents of violence and aggression has continued to increase. Focused work has commenced at Mitford Unit. The Trust wide Safety Group are reviewing incidences of violence and aggression in the context of quality and safety, patient experience, and staff wellbeing as well as learning from other areas. Rajesh noted that long-term segregation and prolonged seclusion continues to decline.

Sarah Rushbrooke referred to the section of the report on commitments to patients and carers and referred to the decision made to increase the trajectory and standard for patient experience. Whilst it is felt the Trust should be achieving the highest standards possible in terms of patient experience, a sustained improvement has been noted.

Sarah referred to the forthcoming launch of the new patient experience survey 'Your Voice' which will enable more opportunities for people to feedback their experience. Sarah advised an update will be provided to a future Quality and Performance Committee.

Lynne Shaw noted the continued increase locally, regionally, and nationally in relation to mental health-related sickness absence.

Regarding training trajectories, work is ongoing to review the training needs across the Trust. This will include prioritisation of training needs, identification of appropriate and realistic training standards. The final recommendations from the review will be submitted to the People Committee in May.

Lynne noted that clinical supervision compliance remains off-track despite gradual improvement therefore a focused piece of work will be undertaken to improve this further.

Regarding the Trust's financial position, Kevin Scollay noted that Trust remains on track to deliver its control total for the year, in-line with the plan.

Darren Best commended the work to reduce out of area placements. This represents a significant achievement, particularly for service users, their families, and carers.

Resolved:

- **The Board received and noted the Integration Performance Report (Month 10)**

2. STRATEGIC AMBITION 1 – QUALITY CARE, EVERY DAY

2.1 Quality and Performance Committee Report

Louise Nelson noted that the Committee has been restructured to include a specific subject for a 'quality focus' at the beginning of each meeting. Safer staffing was the subject of the January meeting, and a walk-through of the new safer staffing report was provided including how the report will align to the IPR to provide assurance as opposed to data, whilst still meeting the requirements of the National Quality Board.

The Committee terms of reference were reviewed which includes attendance of Group Directors. The IPR report was discussed in detail with the committee receiving a high level of assurance and areas of improved performance in some areas. In terms of areas of concern, the Committee continued to have oversight of the actions and mitigations in relation to waiting times for children and young people and neurodevelopment pathway changes.

The Committee received a detailed update on the new service user and carer experience survey 'Your Voice' including preparation for launch, and assurance around accessibility issues and mediums for distribution and completion of the survey. In the meantime, responses to the current 'Points of You' survey continue to increase.

Key decisions made by the Committee included the closure of two CQC Must Do action as it was felt that sufficient evidence was in place in terms of the impact of the actions taken. The Committee also agreed to the reopening of one action relating to body maps and recording of physical observations

following the use of restraint. This was due to further work being required to make the necessary improvements following the outcome of a recent clinical audit.

Louise referred to the implementation of the new operational structure and a discussion on the implications for service and the workforce during the transition period.

Resolved:

- **The Board received and noted the Quality and Performance Assurance Committee Report.**

2.2 Mental Health Legislation Committee Report

Michael Robinson referred to the report and noted that assurance was provided that all Mental Health Legislation policies were in date, with the content remaining compliant with associated legal obligations. The committee reviewed the practice guidance note which cascades legal responsibilities through the organisation and it was agreed that the content was reflective of legislative requirements.

The Committee received an assurance update on an internal audit which provided 'good assurance' in relation to the delegation of statutory functions under the Mental Health Act 1983. The audit also focused on reviewing legal timescales required by law.

The Committee discussed current risks and gaps in assurance where recording of capacity in relation to medication for mental disorder was noted. It was determined that there continues to be a low compliance rate in the completion of the local forms. To improve compliance, localities have been tasked to look at different ways to improve and provide feedback at the next Mental Health Legislation Steering Group (MHLSG). Michale also noted that a recommendation has been made that an internal audit be carried out in 2024/25 on the consent to treatment provisions within the Act.

There was a decrease in compliance with Mental Health Act training from 63% in quarter 2, to 59% in quarter 3 due to long term trainer absence. The trainer has now returned to work; therefore, it is expected that there will be an increase in the number of staff trained in the following months. There will be a training report produced for a focussed discussion at the next meeting in May.

Due to the reorganisation of departments providing services and support around legal frameworks it has been identified that the Mental Capacity Act is not currently consistently applied across the Trust. To address this, the remit of the MHLSG is to be broadened to steer and monitor compliance with, and the application of, the Mental Capacity Act 2005.

There is likely to be traction on the Mental Health Bill towards the end of the year. The draft Bill will replace the MHA 1983 and therefore bring many changes to how legislation is applied in practice. The MHLSG will ensure the Committee are kept up to date and provided with assurance in respect to any changes.

The Committee was informed that successful recruitment of panel members has been carried out with 51 panel members appointed. The MHL department have been exploring different ways to increase the representation of panel members from diverse communities. This included the creation of a targeted advert to encourage people to come forward for a discussion.

Michael advised there are no Board Assurance Framework Risks aligned to the committee however there are risks managed at directorate and local level within the organisation.

Resolved

- **The Board received and noted the Mental Health Legislation Committee Report.**

3. STRATEGIC AMBITION 2 – PERSON LED CARE, WHERE AND WHEN ITS NEEDED

3.1 Programme update Report

Ramona Duguid explained the Trust has in place an annual plan for 2023/24 which builds on the work introduced in 2022/23 across key programmes of work relating to community transformation, urgent and inpatient services, Children and Young People Service and Adults Learning Disabilities and Autism.

Ramona referred to community transformation and the 7 pioneering teams developing new ways of working including the use of the new RiO developments to assessment and care planning to support the improvements relating to clinical risk and safety planning. Regarding the urgent and inpatient programme, Ramona briefed the Board on the launch of the quality framework across all working age adult acute wards and ongoing work within older people services and the trauma informed training pilot which commenced in December 2023.

Ramona referred to work around admission and discharge standards which had a positive impact on bed occupancy, lengths of stay and the out of area position. A review of the crisis workstream took place in February 2024 and a number of key priorities were identified which will define the programme of work over the next 12 months again, with greater alignment with community transformation.

Another key area of focus work is linked to CYPs neurodevelopment pathway and continued discussions with the NENC ICB.

Autism and learning disability training continues while awaiting the ratification of the Code of Practice in conjunction with the Oliver McGowan training. The Trust has secured additional funding to provide dedicated pharmacy support on STOMP (stop over medication of people with a learning disability, autism, or both) and STAMP (Supporting Treatment and Appropriate Medication in Paediatrics) programmes.

David Arthur asked for clarification on the adult learning disability and autism improvement programme which is currently paused. Ramona noted that the work was paused linked to the transforming care agenda but recognised the Trust continued the focus and ongoing developing of STOMP and STAMP.

Brendan Hill asked for clarity around the new draft specification for inpatient services with the expectation that Trusts will move to implementation by 2025, noting the impact on community and crisis services with an expected increase in home-based provision. Ramona Duguid mentioned there is a need to review the support, and commissioning arrangements across health and care in the next five years, including potentially difficult decision in terms of potential disinvestment in some areas to support moving capacity closer to people's homes and communities. It is important that the Trust is fully embedded in such discussions with the NENC ICB to review the process for making such transitions to community-based support, which while positive, needs to be undertaken with the leadership and support from ICB colleagues, and in an open and transparent way.

Darren Best referred to the trauma informed training pilot and asked for an update following implementation in December. Ramona noted that the inpatient programme includes further mandatory training which will be a commitment as part of training priorities 2024/25 using the learning from the pilot. Ramona suggested providing a summary of the evaluation to a future meeting of the Quality and Performance Committee. In terms of the trauma informed care training, Lynne Shaw noted that an external trauma informed specialist and the Trust Lead for Trauma Informed Care will be delivering an update to the April Trust Leadership Forum. James Duncan also noted the importance of recognising the need to understanding of what it means to be a trauma informed organisation, as well the training aspect.

Resolved

- **The Board received and noted the Programme update Report.**

4. STRATEGIC AMBITION 3 – A GREAT PLACE TO WORK

4.1 People Committee Report

Brendan Hill confirmed the Committee continues to meet on a quarterly basis but advised that two additional 'deep dive' meetings will be held each year. The membership of the Committee has also expanded to include Group Nursing Director representation.

There continues to be a decrease in clinical supervision compliance and Brendan noted this remains an area of focus for the CQC as part of the Trust's Must Do actions. The Committee noted a gap in assurance regarding the development of a process to agree staffing establishments which will form a significant part of the workforce development plan. It was noted that despite the priority focus on reducing temporary staffing, having a substantive and clear workforce plan would significantly contribute to the Trust's strategic ambitions.

The move towards implementation of a new operational structure from April 2024 and the impact of this on the development of the workforce plan was recognised. The new structure will provide an opportunity from a workforce perspective to provide clarity on pressure points across the organisation in terms of staffing establishments, use of temporary staff, training needs, and staff development.

Brendan highlighted a positive improvement in appraisal rates towards the 85% standard and the 2023 Staff Survey outcomes have highlighted a number of areas of improvement which will be reported to the June meeting, particularly in terms of measures related to speaking up.

Brendan referred to a presentation provided on work across localities to manage staff sickness absence and the impact this has had to date recognising that the highest levels of sickness both locally and nationally relate to anxiety, stress, depression, and other mental health illnesses. This also reflects post-covid challenges including the impact of increased patient acuity, as well as personal social and economic issues i.e., cost of living, variations in deprivation/income. The outcome of the work undertaken in specific areas provided significant assurance in terms of positive impact.

Brendan referred to Trauma Informed Care (TIC) training which was identified as 'TBC'. It was noted that currently, a standardised package for training did not exist but discussions were ongoing with the Executive Director of Nursing, Therapies and Quality Assurance and the TIC Lead to discuss how the Trust can ensure TIC is embedded in all elements of training.

Examples of Freedom to Speak Up cases are still being explored where this would not compromise confidentiality. The purpose is to promote where speaking up has had a positive outcome and use this to encourage others to speak up, particularly when considering the outcome of the 2023 staff survey. Lynne Shaw mentioned meeting regularly with the Trust's Freedom to Speak Up Guardians exploring how they can find out from staff what is learnt from issues raised as well as exploring the reasons for some staff not feeling able to speak up.

Resolved:

- **The Board received and noted the People Committee Report.**

5. STRATEGIC AMBITION 4 – SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERY DAY

5.1 Finance Report

Kevin Scollay noted that financial performance remains an area of focus regionally due to the underlying position, however the in-year position outlined within the paper remains positive. At the end of Month 10, the Trust has reported a £3.7m deficit on Income and Expenditure, which is in-line with the plan submitted to NHS England. The Trust continues to forecast a breakeven position.

Monthly agency costs are higher than the agency ceiling but are now lower than planned levels. At the end of Month 10, the Trust has spent £13.1m (cumulative) on agency staff against a plan £14.6m and the Trusts nationally applied agency ceiling of £12m. The Trust is currently forecasting to reduce monthly agency expenditure to below the agency cap levels in Quarter 4 this year.

Kevin explained cash balances at the end of January were £14.5m higher than plan, but continue to show a downward trajectory overall.

The Trust Capital spend at the end of Month 10 is £5.2m which is £10.0m 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 of c£6.5m.

The Trust provided a revised Business Case in line with expectations and timescales outlined by the New Hospitals Programme (NHP). The Trust has experienced delays on this programme due to time taken to secure Treasury approval. This has now been secured and the programme is now progressing with a revised financial trajectory.

Resolved:

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

5.2 Resource and Business Assurance Committee (RBAC) Report

Paula Breen mentioned the Committee were advised that the current planning round is moving at significant pace with multiple actions being taken to navigate this. Given the pace of the planning round and the scheduling of quarterly RABAC meetings, it was agreed that regular meetings would be held with the Chairs of both RABAC and Audit Committee to ensure they are appraised of the progress being made in coming weeks.

Paula referred to the impact of the change in accounting rules relating to IFRS 16 (International Financial Reporting Standard 16), which has a significant adverse impact (c£6m) on the financial position due to technical changes to financial reporting. Paula provided assurance that this will not count towards the Trusts financial performance metric for the year and so were assured this does not need to be mitigated for the 23/24-year end position.

Paula explained that Digital agenda has been incorporated within the RBAC terms of reference and delegated responsibility from the Board in terms of assurance and oversight. An update to the Committee was provided from the Chief Information Officer which outlined the development of the current digital strategy, an update on progress against the projects contained with this, and information relating to the national and NENC ICS digital agenda. The awareness and assurances supporting the digital agenda are a key area of focus for the Committee.

Paula referred to Provider Collaboratives which has also been aligned to RBAC, having been transferred from the disbanded Provider Collaborative, Lead Provider Committee. An update was provided on two incidents within Adult Eating Disorder services run by a neighbouring Trust, the committee heard assurances on the escalation of the issues with the commissioning hub and the actions being taken.

Kevin Scollay mentioned Board Assurance Risks were also discussed at RBAC with one of the risks relating to the Green Plan with a recommendation to the Board to downgrade the risk as outlined in the report.

Darren Best requested for a fuller update at a future Board meeting on Digital Innovation.

Resolved:

- **The Board received and noted the Resource, Business and Assurance Committee Report.**

Action:

- **Digital Innovation update to be provided at a future Board meeting.**

6. STRATEGIC AMBITION 5 – WORKING FOR AND WITH OUR COMMUNITIES

6.1 System working report / policy updates

James Duncan referred to NENC ICS with a focus on devising a plan for next year but noted the national delay of planning guidance and an unclear process of submitting plans through NHS England. James advised that the Trust is required to submit a high-level plan by 15 March 2024.

James referred to capital planning noting the Trust is undertaking work to develop an infrastructure strategy for the NENC ICS in the context of risks and needs for investment across the system.

James noted that the Trust has been invited, along with other partners, to comment on the NENC ICB priorities for 2024/25. The Trust is working with Tees Esk and Wear Valley NHS FT to submit a joint response to the priorities.

Resolved:

- **The Board received and noted the system working report / policy update.**

6.2 Charitable Funds Committee

Louise Nelson advised that she will be standing down as Chair of the Committee and Vikas Kumar will take up the role from April 2024. Louise will remain as a member of the Committee.

Louise provided an update on discussions as part of the regional meeting of North East and North Cumbria Integrated Care System NHS Charity Committee Chairs on shared learning and opportunities for more joined up working across the region. Vikas will also join the group.

Louise mentioned that eight new funds were opened during period aligned to the Trust's successful bid in securing £154k of the NHS Charities Together Stage 3 Grant funding for eight special projects across the Trust. Louise explained that the Charity embarked on a rebrand and relaunch following the additional resource to support the charity following the transfer of the function into the Communications and Marketing Team, the appointment of an apprentice-level post and securing additional NHS Charities Together funding for an additional post for a period of 12 months. The additional resource has had a significant impact on the awareness of and reach of the charity during recent months.

Louise explained that in line with the improved governance arrangements, the Committee continues to meet monthly to review and approve bids for fund use. 35 applications to withdraw from specific funds and nine applications were received to withdraw from the Shine Fund. The impact of the funds on patient care, support for carers and staff continues to be shared in line with the Charity Annual Plan and Strategy. The improved communications and engagement to support the charity outlines the positive impact initiatives can have on the wellbeing of those who use our services, as well as our workforce.

Darren Best commended the work of the team noting the increase in visibility of the charity internally and externally.

Resolved:

- **The Board received and note the Charitable Funds Committee Report.**

7.1 Fit and Proper Person Requirements (FPPT) Report

Debbie Henderson referred to the report which provided an overview and assurance of the implementation of the new FPPT requirements, supported by the development of a new policy for

approval by the Board. Audit Committee supported the policy and the work undertaken to implement the new, more robust process.

The paper highlights key changes to the FPPT process which came into effect for all NHS Trusts from 30 September to be fully implemented by March 2024. The framework applies to Board members as well as deputies included in the scope of the FPPT framework.

As the Trust has recently appointed three new NEDs, we are using this new framework for each NEW candidate appointed. Section 5 of the report highlights key changes to the process.

Debbie mentioned a new requirement for Board members to be subject to social media/media checks with the Trust commissioning an external company to undertake this work. A series of additional fields will be added to the Electronic Staff Record (ESR) to support the Trust's implementation of the new framework, although the ESR system still requires further refinement to support the process, for example, appraisal information. In the meantime, information will also be held within a centralised location within the Corporate Affairs Team.

Debbie advised that the new process will be undertaken for all employees who fit the criteria, as part of the Trust's annual reporting process. Debbie also advised that a request has been made to internal audit to review the process every three years.

Approved:

- **The Board approved the new Fit and Proper Person Requirements process and policy.**

7.2 Audit Committee Assurance Report

David Arthur advised that key areas of focus at the January meeting were consideration of the first review of the new Board Assurance Framework, noting the key risks to the achievement of the Trust strategic ambitions, the level of assurance received thereon via the Board Committee framework and explained the importance of ensuring the new approach to risk management is embedded across the organisation.

A detailed update was provided on digital risks, and particularly the update on the electronic healthcare records system RIO upgrade. Issues around management of risks associated with IT and digital matters are being well controlled and a high level of assurance was received from the Chief Information Officer.

Devolving the ability to create bespoke reports and dashboards to other teams across the Trust brings the challenge of managing access permissions. To resolve this, the Digital Services team have implemented additional security measures to be applied to Power BI (business intelligence) reports to ensure users only have access to data relevant to their job role.

David mentioned assurance was received in relation to digital risks, review of the new processes and policy relating to the Fit and Proper Person Test, receipt of the External Audit engagement letter, and updates on Internal Audit and counter fraud progress.

David referred to the appropriateness of the Trust Audit Committee Chair, taking up the role as Board Member of Audit One (Internal Audit). It was agreed that there was no conflict of interest, and that this appointment should proceed. All wavers and breaches of Standing Financial Instructions were reviewed and approved and a scheduled update on assurance from the Resource and Business Assurance Committee was stood down due to the rescheduling of RABAC, which took place following the meeting of the Audit Committee.

Resolved:

- **The Board received and note the Audit Committee Report.**

8. Any Other Business, Items for Information

8.1 Questions from the public
Ruth Berkeley, Local Authority Governor for South Tyneside mentioned within South Tyneside Council elected members have made a pledge around climate change and asked if CNTW would like to also make a pledge. Darren Best asked for Ruth to send further information.

Tom McLaughlan referred to the CEO Report regarding connecting with deprived areas and is Chair of Hallbank Gate Hub setting up a group named 'Blossoms' a dementia café working alongside Dementia Carers Count. Tom asked if the Trust would be interested in supporting the hub. James Duncan suggested Lynne Shaw make contact out-with the meeting to discuss further.

Date and time of next meeting
Wednesday 5th June 2024, St Nicholas Hospital, Jubilee Road, Gosforth, NE3 3XT
Trust Board Room and live-streamed.

1.4 ACTION LOG AND MATTERS ARISING FROM PREVIOUS MEETING

Darren Best, Chair

REFERENCES

Only PDFs are attached

1.4 BoD Action Log PUBLIC at June 2024.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting held in public

Action Log as at 5 June 2024

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					
06.03.24 (6)	RABAC Report	Digital Innovation update to be provided at a future Board meeting	Kevin Scollay	February 2025	Included on Board planning
Completed Actions					
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	March 2024	Action to be monitored at People Committee (6/3/24)
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	TBC	Included on Q&P action log

2. STRATEGIC AMBITION 1 - QUALITY CARE, EVERY DAY

Darren Best, Chair

2.1 QUALITY AND PERFORMANCE COMMITTEE ASSURANCE REPORT

Louise Nelson, Committee Chair

For Assurance

REFERENCES

Only PDFs are attached

2.1 QP Committee Assurance Report 01.05.24.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Wednesday 5th June 2024

Name of Board Committee	Quality and Performance Committee
Date of Committee meeting held	1st May 2024
Date of next Committee meeting	12th June 2024

1. Chair's summary

Quality Focus: Trust Approach to Violence & Aggression and Draft Final Response to HSE Improvement Notice. This was a key quality presentation for Q&P and a challenging and robust discussion took place.

Key themes and areas of focus included policies and procedures, people with dedicated skills, day to clinical and managerial leadership, data versus Intelligence, patient safety and staff safety.

The response to the HSE Improvement Notice was also discussed.

To note for assurance:

- The Development of the new Violence and Aggression Steering group
- The IPR will now include high level detail in relation to the number of violence and aggression incidents from both a staff and patient perspective.
- Q&P to undertake a formal review in 6 months both in terms of progress against the improvement notice response and the work undertaken by the violence and aggression sub group.

Integrated Performance Report (IPR)

Ongoing improvement in patient flow, out of area bed occupancy and in sustaining the improvements seen in PLT referrals.

2 indicators relating to crisis remain a concern Q&P will have a Quality Focus in July.

12-month review of the IPR has been undertaken and some changes, removing some indicators and introducing new ones such mental health act indicators relating to human rights. A summary report outlining changes to the IPR will be shared at the next meeting.

Community Services Waiting Times Update

Some of the pathways in relation to working age adults and older people have made significant improvements compared to the same time last year.

93% of the 5,386 children and young people waiting longer than 4 weeks (as of March 2024) are on a Neurodevelopmental pathway. This will be an area of quality focus at the June

committee. The pathway review is progressing well. A significant area of concern relates to the adult ADHD waiting list which currently has over 10K individuals. Early conversations with the ICB regarding the implementation of a radically different approach. A paper will be presented to the EMG in June.

Safer Staffing Report

The revised report presented which is aligned to IPR giving more enhanced commentary on key risks and assurances. The report will also have a focus relating to the Quality topic each month, this will be Crisis for July Q&P.

CQC

Must Do Update report – revised timescales and actions presented. Discussed CQC letter re Bede ward.

Shanley/MMH

The trust's response to the Shanley and Nottinghamshire report recommendations discussed and to be added to the June agenda.

2. Current risks and gaps in assurance, and barriers to closing the gaps

Neurodevelopmental Pathways – Waiting Lists, for Quality focus in June 20204
Crisis Services – for Quality focus at Q&P July 20204

3. Key challenges now and in the medium term
Recommendations and considerations following the Shanley/MMH and Nottinghamshire Reports/Reviews

4. Impact actions taken to date are having on the achievement of our strategic ambitions
Nil to escalate

5. Barriers to progress and impact on achievement of strategic ambitions
Nil to escalate

6. Actions to be taken prior to next meeting of the Committee

Nil to escalate

7. Items recommended for escalation to the Board at a future meeting

For Board to see the revised Safer Staffing report for information and assurance

8. Review of Board Assurance Framework and amendments thereon

4 identified BAF risks for the Quality and Performance Committee, discussed and 2 BAF risks changed.

CQC Compliance – assurance throughout the meeting particularly the response to HSE, V&A steering group and ongoing monitoring of Must Do actions Q&P agreed that this isn't a BAF level risks and would be managed at Corporate risk level.

Failure to Deliver Transformation Plans – This BAF risk relates directly to service delivery therefore it is proposed that both risks are reviewed jointly and merged. Q&P agreed.

It was noted that the revised BAF risks would be presented at the Board of Directors meeting on 5 June 2024.

Quality and Performance Committee		
Risk	**Score**	**Gaps in assurance**
2510 – Due to increased demand and capacity the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services	4(L)X4(I) 16	• Full implementation of SBAR (Situation, Background, Assessment, Recommendation). • Keeping In Touch process for service users on assessment waiting lists. • Introduction of Dialogue+. • Fully implement 4 week waits. • Introduce the Trusted Assessment concept into community services. • Confirm the role and function of both community and crisis services at the interface of these pathways. • Limited acute inpatient alternatives at a place or system level (crisis housing) • Lack of specialist provision for some client groups (autism). • Limited availability of seven-day week service provision from both an inpatient and community perspective. • Lack of intermediate care opportunities.
2512 – Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern	4(L)X4(I) 16	• Implementation of PSIRF requiring extensive engagement and training of staff to ensure that their practice changes to align

		with the new systems, processes and culture changes. • Outcome measures will need to move from numbers and data around compliance with timescales to assessing how learning is shared and improvements embedded.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Leads if required.

Louise Nelson
Quality and Performance Committee Chair

Sarah Rushbrooke
Executive Director of Nursing Therapies and Quality Assurance

Date: 20th May 20204

2.2 MENTAL HEALTH LEGISLATION COMMITTEE ASSURANCE REPORT

Michael Robinson, Committee Chair

For Assurance

REFERENCES

Only PDFs are attached

2.2 MHLC Assurance Report 05.06.24.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Wednesday 5th June 2024

Name of Board Committee	**Mental Health Legislation Committee (MHLC)**
Date of Committee meeting held	8th May 2024
Agenda items/topics considered	See below
Date of next Committee meeting	7 August 2024

1. Chair's summary

The members were provided with assurance that the Trust are compliant with the requirements of the Mental Health Act and MHA Code of Practice.

Assurances were provided specifically in relation to:

- Mental Health Legislation policies: all policies were in date with the content compliant with associated legal obligations. Those nearing review were on schedule to be reviewed.
- An update was given on all CQC Mental Health Act Reviewer visits in the previous quarter (5 in total) and action plans are in place to meet the issues raised following those visits. Issues raised in previous visits continue to be addressed.
- The legal timescales in relation to section 5, section 4, section 17E and referrals made to the Tribunal: there were NO breaches reported. Assurance was provided that the Trust continues to monitor the use of sections 62/64 and the use of section 4.
- The Trust has further monitored detention in North Cumbria under the MHA to compare with national trends and data. The Trust will further investigate the use of detention across the regions of the Trust through the Mental Health Legislation Steering Group ("MHLSG").
- The Trust as required by new regulation is putting in place processes to monitor detention by ethnicity of service users. This will continue to be reviewed by the MHLSG.
- The Committee received the results of a review of panel membership including a consideration of the practices of other Trusts in this area. The Committee will review and recommend training and appraisal processes for panel members on the basis of that review.

2. Current risks and gaps in assurance, and barriers to closing the gaps

During the meeting, the Committee noted and discussed the following issues in terms of current risks and gaps in assurance.

<u>Recording of capacity in relation to medication for mental disorder</u>
Whilst there continues to be a low compliance rate in the completion of the local forms, the forms have been reviewed and will be amended as appropriate to make completion more straightforward and the MHLSG is taking steps to improve compliance in this area. The Group Directors for each locality have been tasked to look at different ways to improve compliance. It has been recommended that an internal audit on the consent to treatment provisions within the Act is carried out in 2024/2025. Improvement in this area will be beneficial and the outcome of the audit and the recommendations from the audit will

highlight to the groups what actions are required for improvements to be made. MHLSG will also introduce a task and finish group to look at the barriers to completion of the forms and how to remove these barriers. The Committee will continue to monitor this area.

Mental Health Legislation Training

Whilst there was a decrease in compliance from 63% in quarter 2, to 59% in quarter 3 due to long term trainer absence, the trainer has now returned, and compliance has increased to 67 % in January 2024 and to 73% at the end of April 2024. The Trust-wide review of training will report shortly, focusing on those areas and cohorts where training is particularly required. The MHL training team has worked to improve the ease of access to MHL training which is intended to increase further the numbers completing training. The area will be kept under review, looking at improvements over the last 12 months and supporting improvements in the future.

Interface of MCA and MHA

Due to the reorganisation of departments providing services and support to the organisation around legal frameworks (bringing MHA, MCA, Medico Legal, IG together) it has been identified that the Mental Capacity Act is not currently consistently applied across the Trust. Although it is not necessary to amend their terms of reference to reflect any change, the MHLSG will steer and monitor compliance with, and the application of the Mental Capacity Act 2005 and their agendas will reflect this.

3. Key challenges now and in the medium term

The timetable for legislative scrutiny and enactment of the Mental Health Bill is unclear. The draft Bill will replace the MHA 1983 and therefore bring many changes to how we apply the legislation in practice. The MHLSG will ensure the Committee are kept up to date and provided with assurance in respect to any changes although it appears unlikely that there will be any clarity as to the likely introduction of legislation in the short term.

4. Impact actions taken to date are having on the achievement of our strategic ambitions

Monitoring the use of the MHA 1983

The Hospital managers have several responsibilities within the MHA and one of them is to monitor the use of several sections of the MHA. The Committee was given assurance that the Trust is compliant with the Mental Health Act Code of Practice. There continue to be no breaches in timescales in relation to section 5, section 4, section 17E and referrals made to the Tribunal. The Trust continues to monitor the use of sections 62/64 and the use of section 4.

Hybrid hearings

The Committee was advised that the Trust continues to offer a hybrid approach to hospital manager's hearings. This offers patients choice and ensures empowerment and involvement are at the forefront when organising a hearing for CNTW patients.

The giving of patients' rights

Work continues to be undertaken to review the training package/programme on the giving of rights when a person is detained under the Act (s132). The rights training package will provide vital information to our professionals to ensure compliance with the MHA Code of Practice.

Mental Capacity Act

The Committee was given assurance that the agendas for meetings of the MHLSG will include a focus on the MCA as well as the MHA.

Recruitment of panel members

The Committee was given a review of current membership of the hospital manager's panel and the role undertaken by panel members. After recent recruitment, there are currently 47 panel members sitting. The MHL Department have been exploring different ways to increase the representation of panel members from diverse communities and have reached out to groups within those communities. As a result, there are a number of prospective candidates from minority groups in discussions about the role and the Trust was encouraged to pursue those candidates.

There was recognition of the need to have both training and appraisal of panel members on a regular basis. A review of comparable Trusts identified appraisal practices, often taking place on at least a three yearly cycle. Non-executive directors of the Trust acting as panel members was often the case in the past and was welcomed subject to the need for non-executive directors to maintain their independent status. The MHL department will continue its review and report to the Committee on the appropriate training and appraisal process. It was also noted that panel members currently remain in role for a maximum of 10 years (two periods of 5 years). The review will also consider whether this remains appropriate given the introduction of the appraisal system.

5. Barriers to progress and impact on achievement of strategic ambitions

Nothing to highlight at this stage to the Board.

6. Actions to be taken prior to next meeting of the Committee

Those issues identified in section 2 of this form are areas of ongoing review by the Committee and will be considered at its next meeting.

The Committee will receive and consider the outcome of the review of panel membership, training and appraisal.

Following the update received by the Committee on detentions in North Cumbria at this meeting and the agreed further review on the number of detentions under the various sections of the MHA across the Trust as a whole, the Committee will seek further assurance as to the number of detentions under the MHA compared to similar Trusts.

The Committee will seek further assurances that the Trust is compliant with its obligations to hold data on the ethnicity of service users, particularly those detained under the MHA.

7. Items recommended for escalation to the Board at a future meeting

There are no items for escalation to the Board at this stage as regards compliance with the terms of the MHA and MCA. The Committee would draw the attention of the Board to the recent decision of the Employment Appeal Tribunal in *Lancashire and South Cumbria NHS Foundation Trust v Ms R Moon*. This case determined that panel members may be afforded certain employment rights arising from their role. Whilst each case would be assessed on its particular circumstances, the MHL legal team is assessing the possible implications for the Trust.

The Committee would also draw attention to the further work on, panel membership, detention numbers and ethnicity data referred to a paragraph 6 above.

8. Review of Board Assurance Framework and amendments thereon

The Committee holds no BAF risks and therefore there are no such risks to report as all are managed at corporate or local level with appropriate assurance in place. The minutes of the MHLSG showing the consideration of risks aligned to that committee were considered and will continue to be reviewed by the Committee.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.

Michael Robinson
MHL Committee Chair
Date: 16th May 2024

Dr Rajesh Nadkarni
Medical Director & Deputy Chief Executive
Date: 16th May 2024

2.3 INTEGRATED PERFORMANCE REPORT ? QUALITY CARE, EVERY DAY

Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance / Rajesh Nadkarni, Deputy Ch

For Assurance

REFERENCES

Only PDFs are attached

2.3a Board Cover Sheet Jun-24 - IPR - Month 1 24-25 dataRD.pdf

2.3b Trust IPR for Board Jun24 - April2024 Data v2.1.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**5th June 2024**
Title of report	**New Integrated Performance Report (Apr-24 data)**
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	**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		Executive Team	
Audit		Executive Management Group	20.05.24
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	X	Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety and experience	X	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Quality care, every day – We want to deliver expert, compassionate, person-led care **BAF Risk 2511** – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. 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. **BAF Risk 2543 –** Failure to deliver our transformation plans around the model of care to address issues relating to community and crisis infrastructures, and demand for inpatient provision which could compromise quality, safety, and experience of service users. SA2 **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. **BAF Risk 2542** – Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3 **BAF Risk 2544** - Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up. SA3 **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**.** **BAF Risk 2546** - Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure. SA4

New integrated Performance Report (Apr-24 data)

Summary

The Integrated Performance Report has been running successfully for a year, and as the Trust moves into 2024/25, the core set of performance measures have been refreshed in line with national guidance, operational changes and the refreshed Trust Annual Plan for 2024/25.

There are small number of around 40 measures which have been agreed by the Executive Team to provide a high-level summary of the Trust performance against the Annual Plan 2024/25. Many more measures will be reported through the Trust at Group level and across other committees in more detailed papers. The IPR report will summarise a high-level progress report on a monthly basis against the annual plan areas. The Trust level report goes to EMG, Q&P Committee and Board. It is also available to the public, partners and ICB via the Board papers.

Feature reports for 2024/25 will be added to the IPR throughout the year to cover the following relevant areas for example:

- **Benchmarking** key summary update
- **Annual Plan –** full summary of progress on a six-monthly cycle. To include actions and milestones from the full plan.
- **Health Inequalities –** summary of key measures for access compared to protected characteristics and other inequalities data.
- **Specific Improvement action plans –** as and when required – refer to the monitoring of underperformance in the Performance Framework.
- **Deep Dives –** review of waiting lists of other performance issues.
- **NHS E Oversight and Assessment Framework Metrics**

There are two tables in appendix 1 and 2 that show both the 2023/24 metrics and the new 2024/25 metrics and the reasons why these have been changed.

Appendices

- Appendix 1: Current Metrics IPR – 2023/24
- Appendix 2: New Metrics IPR – 2024/25

Recommendation for Board:

- NOTE the new measures as described in appendix 1 and 2.
- Review the performance within with the New Integrated Performance Report for Month 1.

Tommy Davies
Head of Performance and Operational Delivery

Ramona Duguid
Chief Operating Officer

22nd May 24

Appendix 1 : Current Metrics IPR – 2023/24

Current Metrics IPR – 2023/24	Remain/Remove/Replace
Commitment Section	
How was your experience? (FFT Question)	Remains- move target to 90% from 95%
Did we listen to you?	Remove - No longer a question
Were staff kind and caring?	Remove – report in patient report
Did you feel safe?	Remains move target to 90% from 95%
Were you given helpful information?	Remove – report in patient report
Great Place to Work	
Turnover	Remove – report in People Committee
Sickness in month	Remains
% of Training Compliance (Courses with a standard)	Remains but split training btwn Ops and All Staff TBC
Appraisal rate	Remains
Clinical Supervision	Remains
% staff who said Organisation is proactively supporting staff HWB	Remove – report in People Committee
Quality Care	
Restrictive intervention incidents	Remove – replace with MRE and Prone Restraints
Safeguarding and Public Protection Incidents (SAPP)	Remove – Report in Safer Care Report
Long term segregation and prolonged seclusion	Remains
Harm Incidents	Remains – PSIRF replacement
Aggression and Violence	Remove - replace with assaults
Number of complaints	Remove –not telling us much
Care Plans Compliance	Remove – Replace with Safety Plans
Risk Assessment Compliance	Remove – Replace with Safety Plans
CPA Completed Reviews	Remove – CPA being replaced
Staffing Fill Rates	Remove – report at ward level in Safe Staffing report
Person Led Care	
Out of Area Placements Bed days	Remains
Bed Occupancy including leave (open beds on RiO)	Remains
% Adult inpatients discharged with a length of stay > than 60 days	Remains – internal target proposal – 20%
% Older Person inpatients discharged with a length of stay > than 90 days	Remains - internal target proposal – 40%
Clinically Ready for Discharge (formerly DTOCs)	Remains
Crisis - % Very urgent seen within 4 hours (Adults and OA)	Remains - internal target proposal – 80%
Crisis - % Urgent seen within 24 hours (Adults and OA)	Remains - internal target proposal – 90%
Psychiatric Liaison 1hr Response for patients in A&E	Remains - internal target proposal – 80%
Psychiatric Liaison 24hr Response for patients inpatients	Remains - internal target proposal – 90%
72 hour follow up	Remove – report only when in exception
4 week waits to Treatment - Adults and Older Adults	Remain - internal target proposal – 85% with trajectory across the year
4 week waits to Treatment - CYPS	
CYPS Neuro waits	
IAPT Moving to Recovery	Remove – report only when in exception
CYPS Eating Disorder waits - Urgent	Move to Care Group reporting – very low numbers fluctuate the performance
CYPS Eating Disorder waits - Routine	
EIP	Remove – 24mths on target –report only when in exception
Sustainable	
Live within our means	Remains – change to running total
Capital Programme balance	Remains
Cash balance compared to plan	Remains

Appendix 2 : New Metrics IPR – 2024/25

New Metrics IPR – 2024/25	
Commitment Section	
How was your experience (FFT Question)	90% Stretch Standard
How was the care we provided?	90% Stretch Standard
Did you feel safe?	90% Stretch Standard
Great Place to Work –	
Sickness in month	
% of Training Compliance - Priority Training – All Staff	
% of Training Compliance - Priority Training – Clinical Staff	
Appraisal rate	
Clinical Supervision	
Quality Care	
MRE Restraints	New
Prone Restraints	New
Long term segregation and prolonged seclusion	
Assaults on Patients	New
Assaults on Staff	New
% of patients with a Safety Plan	New
Reducing incidents of self-harm	New – From Annual Plan measures
Unexpected Deaths	New – From Annual Plan measures
918 - Rights at Point of Detention	New
916 - Record of Capacity/ CTT (Part A) at point of detention	New
Person Led Care	
Out of Area Placements Bed days	
Bed Occupancy including leave (open beds on RiO)	
% Adult inpatients discharged with a length of stay > than 60 days	20%
% Older Person inpatients discharged with a length of stay > than 90 days	40%
Clinically Ready for Discharge (formerly DTOCs)	
Crisis - % Very urgent seen within 4 hours (Adults and OA)	80% Standard but monthly trajectory
Crisis - % Urgent seen within 24 hours (Adults and OA)	90% Standard but monthly trajectory
Psychiatric Liaison 1hr Response for patients in A&E	80% Standard but monthly trajectory
Psychiatric Liaison 24hr Response for inpatients	90% Standard but monthly trajectory
4 week waits to Treatment - Adults and Older Adults	85% Standard but monthly trajectory
4 week waits to Treatment - CYPS	85% Standard but monthly trajectory
Sustainable	
Live within our means (running total)	Change from monthly to running total
Income & Expenditure Forecast	New
All staff WTEs	New
Capital Programme balance	
Cash balance compared to plan	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2024-25 Month 1 (April 2024)

With YOU in mind

Integrated Performance Report - Headline Commentary

Headline Challenges

- **How was your experience?** is off target and deteriorating the last five months
- **% Training Compliance – Clinical Staff Training–** Not all the Clinically prioritised training for staff is being delivered
- A range of new Quality measures on **Restraint, Seclusion and assaults on staff and patients** have been added to the IPR for 24/25. Despite not having specific targets these areas are focused challenges for the Trust to improve and more sophisticated improvement monitoring is being developed.
- **Record of Capacity/CTT at point of detention -** off target
- **% of Patients with a safety plan-** Live from 15th April 2024. Reporting may be impacted during the transition across to the biopsychosocial risk framework
- **Bed occupancy –** off target but improved over 24 months.
- **Clinically Ready for Discharge** – off track but has improved over last 3 months.
- **Adult inpatients discharged with LOS >60 days** – Remaining stable over last 3 months
- **Crisis Very Urgent Referrals seen within 4 hours –** At 43.0%, reported as below average for 8th consecutive month.
- **4-week national standard waiting times**
  All measures have a low level of performance
- **% waiting < 4 weeks to Treatment Adult and Older Adult Waits to Treatment** – 30.5% of referrals have been waiting 4 weeks or less to treatment, performance improved in the month.
- **% waiting < 4 weeks to Receive Help - All CYPS** – 10.9% of referrals have been waiting 4 weeks or less to receive help (5638 out of 6324), of which (5,273 out of 5,773) 91.3% are within the neurodevelopmental pathway.

Key focus areas of concern

- **% of Training Compliance**
- **Crisis Very Urgent Referrals seen within 4 hours**
- **% waiting < 4 weeks to Receive Help – All CYPS**
- **Live within our means**

Positive Assurance / Improvement

- **Commitments** – Your voice was launched on 2nd April 2024. Do you feel safe is on target and has improved
- **Prone Restraints** – reduced significantly over the last 24 months.
- **Out of Area Placement Bed Days** – There continues to be no reported inappropriate bed days since December 2023.
- **Crisis % very urgent seen with 24hr -** meeting new internal target of 85%
- **Older Adult inpatients discharged with LOS >90 days** – 7% improvement in the month and reported below standard
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.8% highest performance reported in 24 months and meeting new internal target of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Highest performance reported in 24 months at 93.0% and meeting new internal target of 85%
- **Clinical Supervision** – 8% improvement in the month but still significantly off 80% target at 59.9%

Mitigations/actions

- **% of Training Compliance —** The new priorities for training have been established and are reported in the IPR for the first time. The 'all staff' training measures are performing well, however, Clinical prioritised staff training is not meeting most of its targets. The targets are for the quarter and the prioritisation and monitoring process has only begun in the last month. With this prioritisation and focus, these key training areas will improve in the quarter. There is still work on going to get all the prioritised metrics into dashboards and this report, this will be completed for the next IPR.
- **Crisis Very Urgent Referrals seen within 4 hours –** There is a continuing review of initiatives related to crisis services, encompassing the flow of the 136-suite, the implementation of Right Care Right Place (which went live in North Cumbria recently), alternatives to admission, community interface, discharge model/in-reach, and the expansion of Mental Health 111 services. Business Units will also provide progress reports on operational performance and measures for Crisis recovery at the Community Oversight Group. *Recovery plans in place & being reviewed*
- **% waiting less than 4-week All CYPS–** The CYPS waiting percentage for those receiving help with 4 weeks is low, largely due to the high volume of Neurodevelopmental patients waiting, caused by significant increases in referrals. There is a new pathway for neurodevelopmental pathways that has been signed off by the Trust and is being rolled out in a phased approach. Further work with NENC system leaders is taking place to discuss how as a system we improve access and experience of CYPS with a neurodevelopmental need. *Recovery plan in place*
- **Live within our means –** The new Groups/Departments have identified specific areas for review to influence financial performance. BDG monthly finance meetings are convened to determine actions regarding the financial status of the Trust and forecasted positions within each locality for the current year. *Recovery plans being developed for 24/25*

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Apr 2024

	Ref	Indicator Name	Variation	Assurance	Performance	Standard	Plan	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Normal Variation	Off target	81.2%	90.0%	Internal	High (Action)	Off target and below average for five months	SR
	C02	How was the care we provided?	SPC N/A	SPC N/A	83.5%	90.0%	Internal	High (Action)	Reported below standard, new question implemented April 2024	SR
	C03	Did you feel safe?	Normal Variation	Achieve at Random	92.8%	90.0%	Internal	Low (On Track)	On target and improved in the month	SR
People	P01	Sickness in Month	Normal Variation	Off target	5.6%	5.0%	National	High (Action)	Improved in the month, NTW Solutions data now removed	LS
	P02	Training Compliance - Priority Training - All Staff	Improvement	Off target	77.8%	100.0%	Internal	High (Action)	Newly prioritised training metrics - excludes NTW Solutions	LS
	P03	Training Compliance - Priority Training - Clinical Staff	Concern	Off target	22.2%	100.0%	Internal	High (Action)	Newly prioritised training metrics - excludes NTW Solutions	LS
	P04	Appraisal rate	Improvement	Off target	76.0%	85.0%	Internal	High (Action)	Not on target but has improved in the month - excl. NTW Solutions	LS
	P05	% Clinical Supervision completed	Normal Variation	Off target	59.9%	80.0%	Internal	High (Action)	8% point improvement in month, consistently off target	LS
Quality Care	Q01	MRE Restraints	Normal Variation	N/Ap	6	N/Ap	N/Ap	Med (Monitoring)	Improved in the month reported below average	RN
	Q02	Prone Restraints	Improvement	N/Ap	51	N/Ap	N/Ap	Med (Monitoring)	51 reported in April, significant improvement over 24 months	RN
	Q03	Long term segregation and prolonged seclusion	Normal Variation	N/Ap	15	N/Ap	N/Ap	Med (Monitoring)	Deteriorating trend ended with an improvement in month	SR
	Q04	Assaults on Patients	Normal Variation	N/Ap	77	N/Ap	N/Ap	Med (Monitoring)	Last four months above average, improved last two months	RN
	Q05	Assaults on staff	Normal Variation	N/Ap	459	N/Ap	N/Ap	Med (Monitoring)	Deteriorating trend ended with an improvement in month	RN
	Q06	% of patients with a Safety Plan	SPC N/A	N/Ap	76.1%	100.0%	Internal	Med (Monitoring)	Inpatients (76 out of 88), Community (4,391 out of 5,783)	RN
	Q07	Reducing incidents of self-harm	Normal Variation	SPC N/Ap	1,229	N/Ap	N/Ap	Low (No Standard)	Deteriorating trend ended with an improvement in month	RN
	Q08	Rights at Point of Detention	Normal Variation	Achieve at Random	95.2%	100.0%	Internal	Med (Monitoring)	Deteriorated in month and off target	RN
	Q09	Record of Capacity/ CTT at point of detention	Normal Variation	Off target	67.6%	100.0%	Internal	High (Action)	Improved in month and off target	RN
Person Led Care	A01	Out of Area Placement bed days	Improvement	Achieve at Random	0	14	Plan	Low (On Track)	There continues to be no out of area placements since Dec 23	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Improvement	Off target	92.6%	85.0%	National	High (Action)	Improved over last 24 months, except current month	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	Achieve at Random	22.6%	20.0%	Internal	Med (Monitoring)	Remaining stable, reported below average for 3rd consecutive month	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	38.9%	40.0%	Internal	Low (On Track)	Improved in the month, below average for 1st time in 3 months	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Off target	10.0%	7.5%	National	High (Action)	Remains off track but has improved for the 3rd consecutive month	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Concern	Achieve at Random	43.0%	50.0%	Plan	High (Action)	92 out of 214, less than half very urgent patients seen within 4 hours	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Normal Variation	Achieve at Random	87.6%	85.0%	Internal	Low (On Track)	375 out of 428. Performance improved in the month	RD
	A08	% PLT ED Referrals seen within 1 hour	Improvement	Off target	80.8%	80.0%	Internal	Med (Monitoring)	Highest reported performance reported for 24 months	RD
	A09	% PLT Ward Referrals seen within 24 hours	Improvement	Achieve at Random	93.0%	85.0%	Internal	Low (On Track)	Highest reported performance reported for 24 months	RD
	A10	% Waiting 4 wks or less to treatment (WAAOP)	Improvement	Off target	30.5%	35.0%	Plan	High (Action)	69.5% (2,479 of 3,568) have been waiting longer than 4 weeks	RD
	A11	% Waiting 4 wks or less to receive help (CYPS)	Normal Variation	Achieve at Random	10.9%	15.0%	Plan	High (Action)	89.1% (5,638 of 6,324) have been waiting longer than 4 weeks	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC N/A	SPC N/A	-£2.5m	-£2.5m	Plan	High (Action)	The Trust delivered a £2.5m deficit in month 1 £0.1m above the plan	KS
	S02	Income & Expenditure Forecast	SPC N/A	No Standard	£3.9m def	£3.9m def	Plan	Low (No Standard)	The Trust is planning a £3.9m deficit	KS
	S03	All staff WTEs	SPC N/A	SPC N/A	8,765	No Std	N/Ap	Low (No Standard)	WTE numbers have reduced by 20 wte since last month	KS
	S04	Capital spend compared to plan (£k)	SPC N/A	SPC N/A	£0.7m	£1.0m	Plan	Low (No Standard)	Plan to deliver the approved capital programme, £2.4m over CDEL	KS
	S05	Cash balance compared to plan (£)	SPC N/A	SPC N/A	£39m	£39m	Plan	Low (On Track)	The Trust cash balances are slightly less than plan at month 1.	KS

Commitments to our Carers & Patients - Headline Commentary

Headline Challenges

The standards were reviewed in April along with the implementation of the new Trustwide survey 'Your Voice' and have now been set at 90% (previously 95%). The standards will be reviewed once the survey has had time to embed.

- **How was your experience? (FFT) –** Performance was reported at 81.2% for April, this was lower than March 24 (84.2%). The 90% standard has not be met. The latest national published FFT score for England is reported at 86.0% (January 24).

Selected Your Voice questions

- **How was the care provided?** – this is the first month reporting on this question as we moved to a new survey, with Your Voice replacing PoY.

Key focus areas of concern

- **How was your experience? (FFT)**
- **How was the care provided?**

Positive Assurance / Improvement

- **Did you feel safe?** - was on track this month.
- A new experience survey for service users and carers was introduced during April. This was co-developed with stakeholders and should offer better opportunities for people to share their experience with the Trust as the questions reflect the current themes for questions that emerged through the engagement process.
- Service users are now receiving the option to complete the survey by email and text as well as letter. Service users have the autonomy to choose a preferred option or opt out from the survey.

Mitigations/actions

How was your experience? (FFT)

- 19 of 203 respondents said their experience was poor. 8 of these experiences relate to crisis or initial response services, not being listened to or staff being dismissive or rude are most often discussed.
- Specialist services had the highest satisfaction rating of 91% and community services had the lowest score of 79% during April.

How was the care provided?

- 197 people responded to this question, with 162 reporting a good experience of the care provided.
- 17 people or 9% of respondents reported a poor experience. 7 of these experiences are in relation to crisis or initial response services.

Awareness sessions are to be made available for staff to help them understand the new dashboard. This will hopefully support the organisation to being more responsive to the people accessing our services and support higher satisfaction scores going forward.

The new survey launched on 2nd April 2024, levels of feedback were reduced, leading to small numbers of negative experiences having a higher impact on the score than in a normal month.

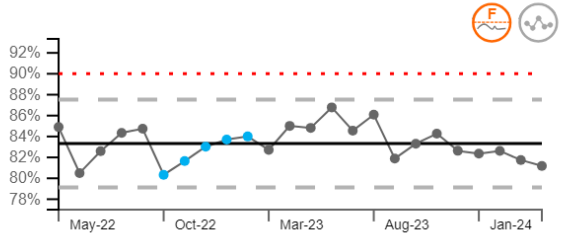
Commitments to our Carers & Patients

Reporting Period: Apr 2024

How was your experience? (FFT)

High (Action)

Ref - C01 Performance - 81.2% Standard - 90.0%



How was the care we provided?

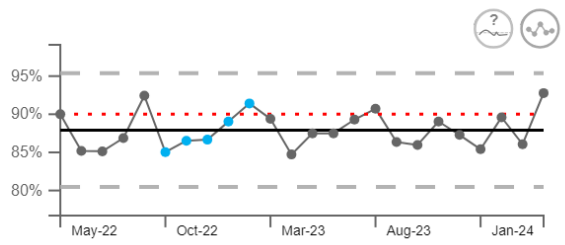
High (Action)

Ref - C02 Performance - 83.5% Standard - 90.0%

Did you feel safe?

Low (On Track)

Ref - C03 Performance - 92.8% Standard - 90.0%



Great Place to Work - Headline Commentary

Headline Challenges

Sickness Absence – The confirmed sickness for March 2024 is reported at 5.6% (excluding NTW Solutions). The provisional sickness for April 2024 is reported at 5.67% remaining above the 5% standard. This now excludes NTW Solutions.

% of Training Compliance (Courses with a standard)

- In March 2024, Priority Training for All Staff is reported at 77.8%.
- Priority Training for Clinical Staff is reported at 22.2%. The reported position for April currently excludes 6 courses that require inclusion, further work is ongoing regarding the addition of these.
- Key challenges remain linked to clinical demand and the ability to release staff to undertake essential training.
- **Clinical Supervision -** performance has improved and is reported at 59.9% compared to March 24 when reported at 51.9%, remaining below Trust 80% standard.
- **Appraisals –** Decreased in the month

Key focus areas of concern

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

Positive Assurance / Improvement

- **Clinical Supervision** – 8% improvement in the month

Mitigations/actions

Sickness Absence

- Analysis of absence in Care Groups to establish themes and trends. Sharing best practice and support mechanisms within new structure.
- Sickness Clinics/sickness meetings continue within the Care Groups monthly, whereby each employee absent for more than 28-days meets with their line manager and Workforce Representative. Short Term absence is monitored, and Review Point Meetings are now well established within groups when staff hit trigger points.
- The Trusts Health and Wellbeing offer continues to be promoted. Our new Occupational Health provider Optima commenced on 1st April 2024.

% of Training Compliance (Courses with a standard)

- The new priorities for training have been established and are reported in the IPR for the first time. The 'all staff' training measures are performing well, however, Clinical prioritised staff training is not meeting most of its targets. The targets are for the quarter and the prioritisation and monitoring process has only begun in the last month. With this prioritisation and focus, these key training areas will improve in the quarter. This data requires further work to add in six courses to the dashboards for reporting purposes.

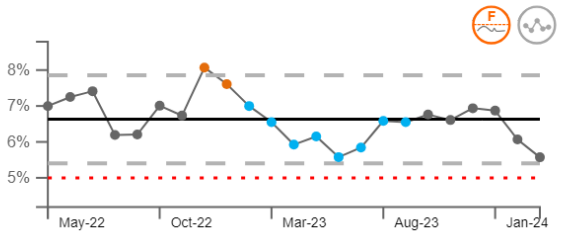
Great Place to Work

Reporting Period: Apr 2024

Sickness in Month

High (Action)

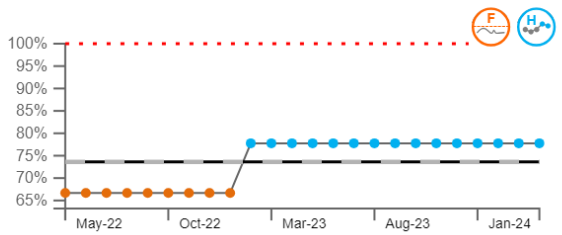
Ref - P01 Performance - 5.6% Standard - 5.0%



Training Compliance - Priority Training - All Staff

High (Action)

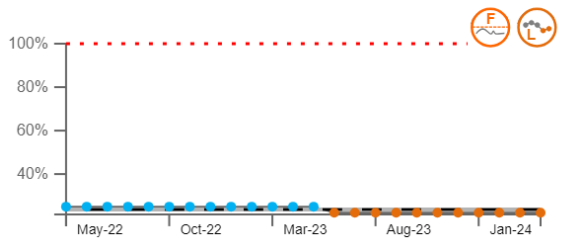
Ref - P02 Performance - 77.8% Standard - 100.0%



Training Compliance - Priority Training - Clinical Staff

High (Action)

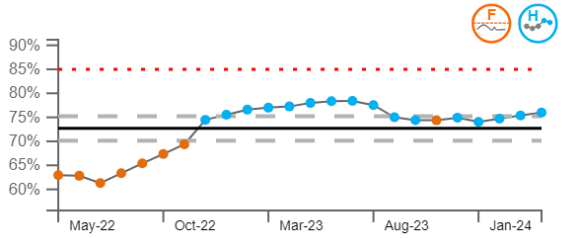
Ref - P03 Performance - 22.2% Standard - 100.0%



Appraisal rate

High (Action)

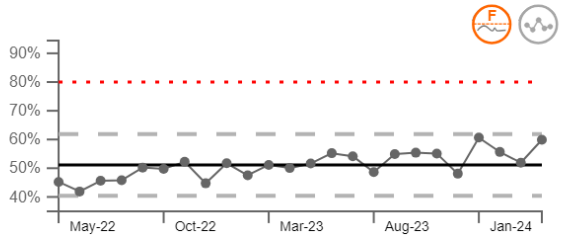
Ref - P04 Performance - 76.0% Standard - 85.0%



% Clinical Supervision completed

High (Action)

Ref - P05 Performance - 59.9% Standard - 80.0%



Quality Care, Everyday - Headline Commentary

Reporting Period: Apr 2024

Headline Challenges

- A range of new Quality measures on **Restraint, Seclusion and assaults on staff and patients** have been added to the IPR for 24/25. Despite not having specific targets these areas are focused challenges for the Trust to improve and more sophisticated improvement monitoring is being developed.

- **% of Patients with a safety plan -** Live from 15th April 2024. Reporting may be impacted during the transition across to the biopsychosocial risk framework
- **Reducing Incidents of self-harm** – is close to target and showing signs of improvement but has consistently not met the target.
- **Rights at Point of Detention** – is consistently off target by 25%

Key focus areas of concern

- **Record of Capacity/CTT at point of detention**
- **% of Patients with a safety plan**

Positive Assurance / Improvement

- **MRE Restraint** - Decreased for the 2nd consecutive month
- **Prone Restraints** – Have reduced at a statistically significantly over the last 24 months.

Mitigations/actions

Record of Capacity/CTT at point of detention

- Following the Mental Health Legislation Steering Group (MHLSG) on 25 April a working group was formed to review the local form to look at any barriers in the completion of the form and to remove those barriers.
- The MHLSG has recommended that an audit on the consent to treatment provisions within the Act is carried out in 2024/2025 by internal audit.

% of Patients with a safety plan

- The new risk framework form went live on 15th April 2024. Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards.

Staff and patient assaults

- One of the PSIRF priorities for the year is prevention and management of violence and aggression. A separate sub group is being established to co-ordinate this work across inpatient services.

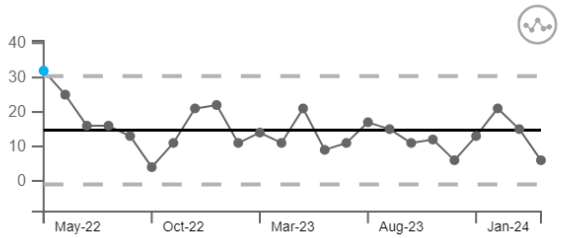
Quality Care, Everyday

Reporting Period: Apr 2024

MRE Restraints

Med (Monitoring)

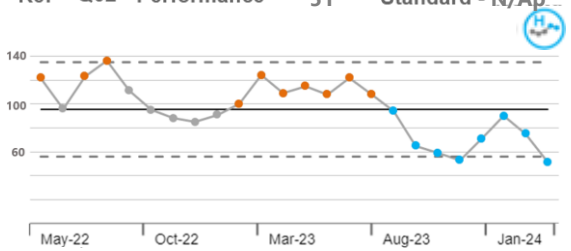
Ref - Q01 Performance - 6 Standard - N/Ap



Prone Restraints

Med (Monitoring)

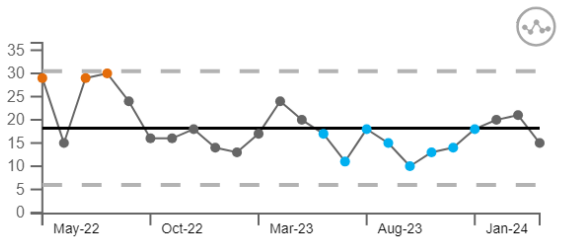
Ref - Q02 Performance - 51 Standard - N/Ap



Long term segregation and prolonged seclusion

Med (Monitoring)

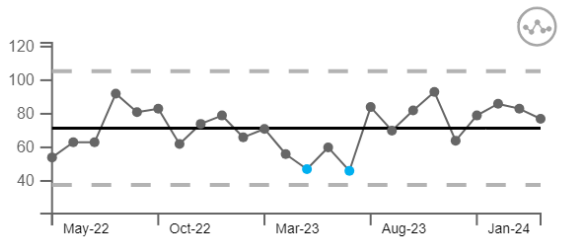
Ref - Q03 Performance - 15 Standard -N/Ap



Assaults on Patients

Med (Monitoring)

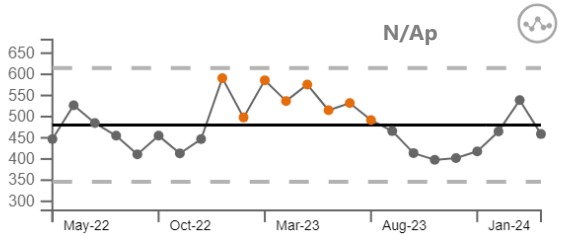
Ref - Q04 Performance - 77 Standard - N/Ap



Assaults on staff

Med (Monitoring)

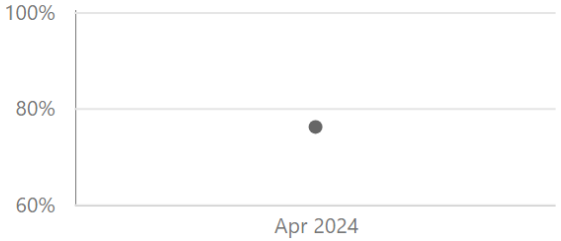
Ref - Q05 Performance - 459 Standard - N/Ap



% of patients with a Safety Plan

Med (Monitoring)

Ref - Q06 Performance - 76.1% Standard - 100.0%

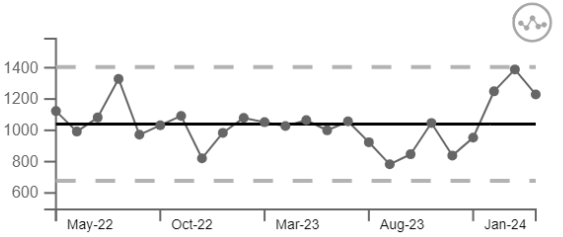


N/Ap

Reducing incidents of self-harm

Low (No Standard)

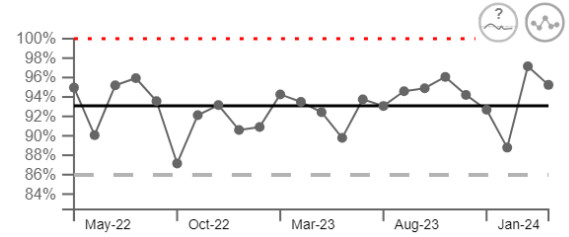
Ref - Q07 Performance - 1,229 Standard - N/Ap



Rights at Point of Detention

Med (Monitoring)

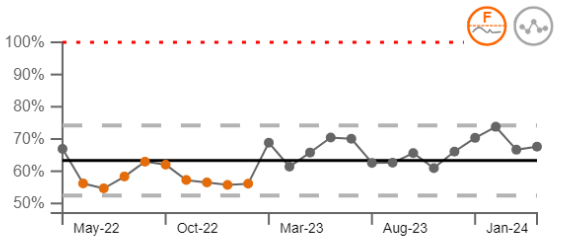
Ref - Q08 Performance - 95.2% Standard - 100.0%



Record of Capacity/ CTT at point of detention

High (Action)

Ref - Q09 Performance - 67.6% Standard - 100.0%



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

Headline Challenges

- **Bed occupancy –** remains high but has improved over 24 months.
- **Clinically Ready for Discharge** – off track but has improved over last 3 months.
- **Adult inpatients discharged with LOS >60 days** – Remaining stable over last 3 months
- **Crisis Very Urgent Referrals seen within 4 hours –** At 43.0%, reported as below average for 8th consecutive month.
- **4-week national standard waiting times**
  All measures have a low level of performance
- **% waiting < 4 weeks to Treatment Adult and Older Adult Waits to Treatment** – 30.5% of referrals have been waiting 4 weeks or less to treatment, performance improved in the month.
- **% waiting < 4 weeks to Receive Help - All CYPS** – 10.9% of referrals have been waiting 4 weeks or less to receive help (5638 out of 6324), of which (5,273 out of 5,773) 91.3% are within the neurodevelopmental pathway.

Key focus areas of concern

- **Crisis Very Urgent Referrals seen within 4 hours**
- **% waiting < 4 weeks to Receive Help – All CYPS**

Positive Assurance / Improvement

- **Out of Area Placement Bed Days** – There continues to be no reported inappropriate bed days since December 2023.
- **Crisis % very urgent seen with 24hr -** meeting's new internal target of 85%
- **Older Adult inpatients discharged with LOS >90 days** – 7% improvement in the month and reported below standard
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.8% highest performance reported in 24 months and meeting new internal target of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Highest performance reported in 24 months at 93.0% and meeting new internal target of 85%

Mitigations/actions

- **Crisis Very Urgent Referrals seen within 4 hours –** There is a continuing review of initiatives related to crisis services, encompassing the flow of the 136-suite, the implementation of Right Care Right Place (which went live in North Cumbria recently), alternatives to admission, community interface, discharge model/in-reach, and the expansion of Mental Health 111 services. Business Units will also provide progress reports on operational performance and measures for Crisis recovery at the Community Oversight Group. *Recovery plans in place & being reviewed*
- **% waiting less than 4-week All CYPS–** The CYPS waiting percentage for those receiving help with 4 weeks is low, largely due to the high volume of Neurodevelopmental patients waiting, caused by significant increases in referrals. There is a new pathway for neurodevelopmental pathways that has been signed off by the Trust and is being rolled out in a phased approach. Further work with NENC system leaders is taking place to discuss how as a system we improve access and experience of CYPS with a neurodevelopmental need. *Recovery plan in place*

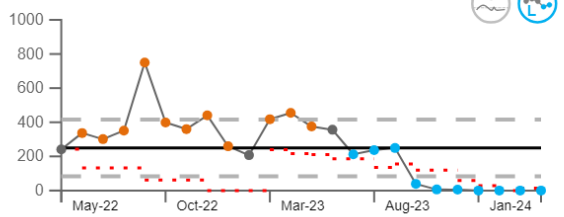
Person Led Care, when and where it's needed

Reporting Period: Apr 2024

Out of Area Placement bed days

Low (On Track)

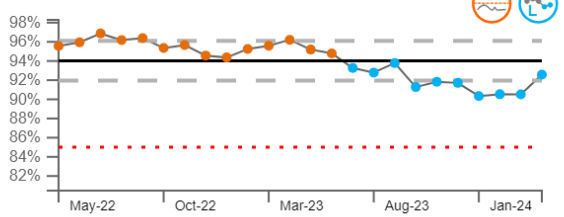
Ref - A01 Performance - 0 Standard - 14



Bed Occupancy including leave (open beds on RiO)

High (Action)

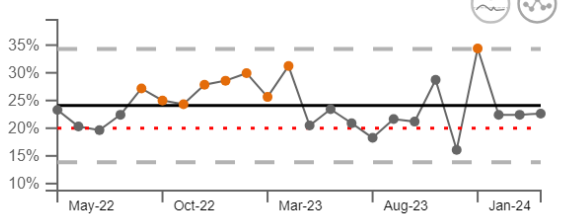
Ref - A02 Performance - 92.6% Standard - 85.0%



% Adult inpatients discharged with LOS > 60 days

Med (Monitoring)

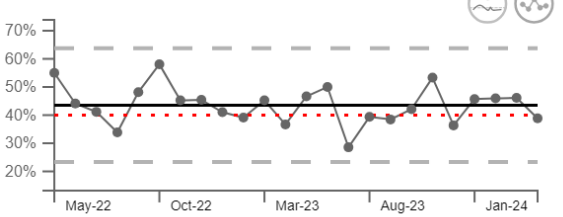
Ref - A03 Performance - 22.6% Standard - 20.0%



% OP inpatients discharged with LOS > 90 days

Low (On Track)

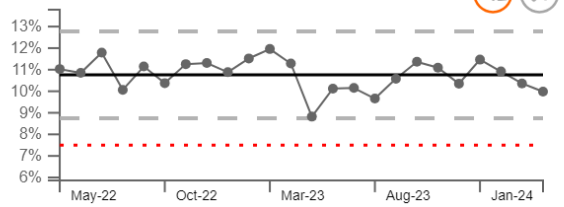
Ref - A04 Performance - 38.9% Standard - 40.0%



Clinically Ready for Discharge (formerly DTOC)

High (Action)

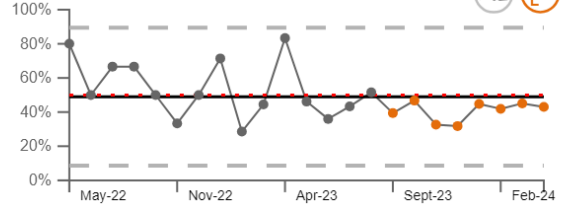
Ref - A05 Performance - 10.0% Standard - 7.5%



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

High (Action)

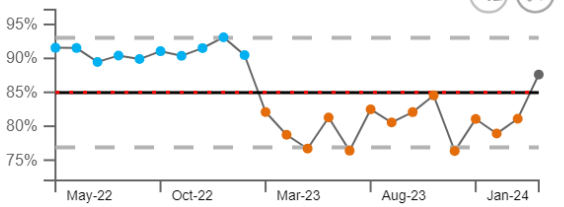
Ref - A06 Performance - 43.0% Standard - 50.0%



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

Low (On Track)

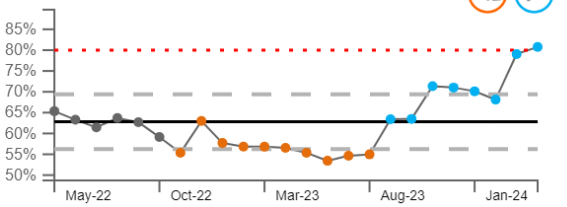
Ref - A07 Performance - 87.6% Standard - 85.0%



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

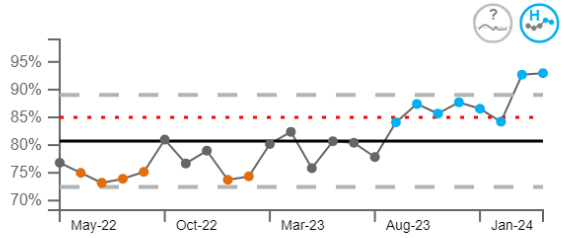
Ref - A08 Performance - 80.8% Standard - 80.0%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

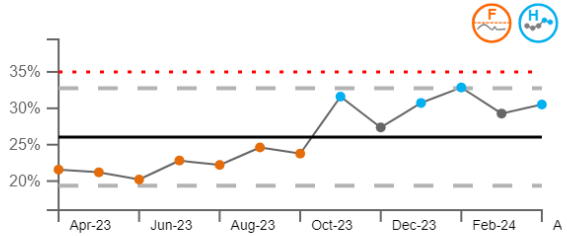
Ref - A09 Performance - 93.0% Standard - 85.0%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

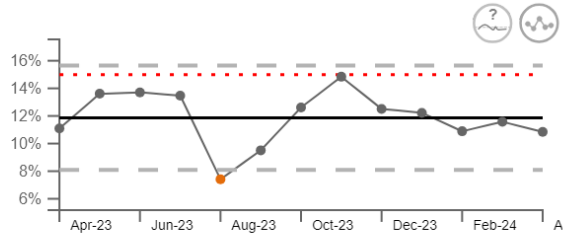
Ref - A10 Performance - 30.5% Standard - 35.0%



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

High (Action)

Ref - A11 Performance - 10.9% Standard - 15.0%



Sustainable for the Long Term - Headline Commentary

Headline Challenges

- At month 1 the Trust is generating a £2.5m deficit.
- This deficit is in line with the financial plan at Month 1. This plan is phased to deliver deficits in the first 9 months of the year and surpluses for the last quarter of the year.
- At the end of Month 1 the Trust has spent £0.9m on agency staff against a plan £0.9m.
- Expenditure on the Trust capital programme is forecast to be £2.4m higher than the plan. The Trust submitted a plan compliant with the CDEL limit allocated to the Trust as requested by the ICB. The trust planned delivery will breach the CDEL limit.
- The Trust has a cash balance of £38.6m at the end of Month 1 which is behind the plan. Trust balances are planned to fall significantly through the year.

Key focus areas of concern

- The Trust is developing detailed plans to deliver the efficiency programme submitted as part of the annual plan.

Positive Assurance / Improvement

- The Trust has reported a reduction of 20 wte from last month. The Trust workforce plan includes a reduction of over 450 wte from April to March. To deliver the financial plan the Trust must manage a significant reduction in the overall wte used.

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 efficiency plans.
- BDG monthly finance will focus time on plans for longer term financial sustainability. The Trust will agree trajectories for service to plan to deliver costs in line with the contracted income by 2027.
- 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.
- Ongoing discussions with the ICB re the pressure on the Trust CDEL for 2024/25. Based on the current programme the Trust will breach the allocated limit. The Trust is seeking slippage to increase the CNTW limit for this year.
- Weekly meeting to review and maximise the Trust cash balances.

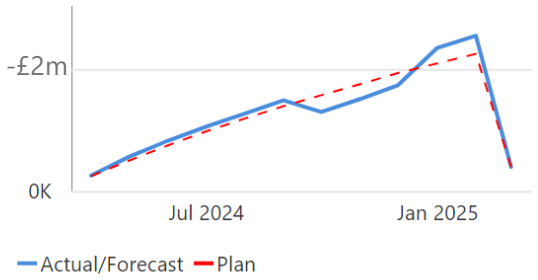
Sustainable for the Long Term

Reporting Period: Apr 2024

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

High (Action)

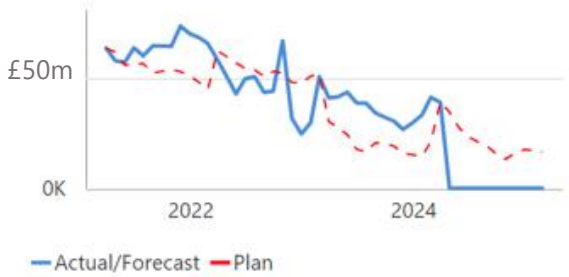
Ref - S01 Actual/Forecast - -£2.5m Plan - -£2.5m



Cash balance compared to plan (£)

Low (On Track)

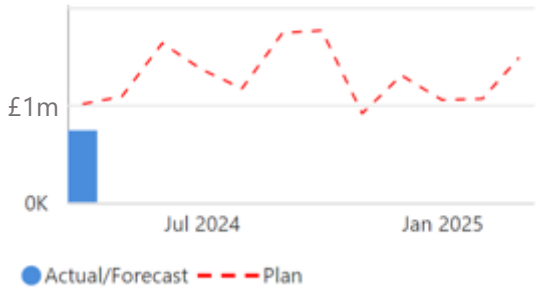
Ref - S05 Actual/Forecast - £39m Plan - £39m



Capital spend compared to plan (£k)

Low (No Standard)

Ref - S04 Actual/Forecast - £0.7m Plan - £1.0m



C01 - How was your experience? (FFT)

Risk Rating - **High (Action)**

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

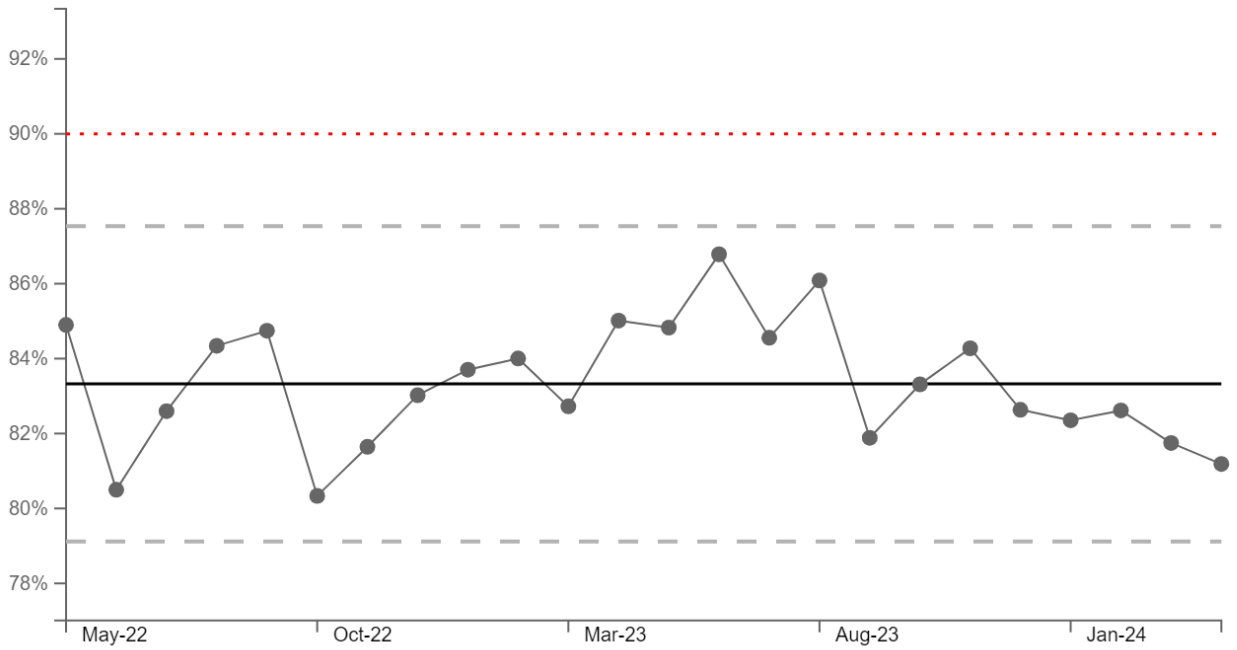
Performance - 81.2%

Standard - 90.0%

Consistently Off target
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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	75.4%	90.0%		
Inpatient Care Group	88.6%	90.0%		
Specialist Care Group	88.7%	90.0%		

Feedback

What the chart tells us

Performance of 81.2% for April was within the expected range of 81.2% to 89% and remains below the standard of 90%.

Root Cause of the performance issue

19 people reported their experience as being poor (6) or very poor (13) during April.

Specialist services had the highest satisfaction rating of 88.7% and community services had the lowest score of 75.4% during April.

Improvement Actions

Numbers of poor experiences were smaller than in previous months, due to lower levels of feedback being offered overall as a new survey was introduced this months.

A new dashboard is being developed and is already available to all staff. This includes tutorial films and user tips to support understanding of functionality, to support staff to get the best from the experiences offered by service users and carers. Staff should be supported to explore this dashboard and be responsive to themes as they emerge.

Expected impact and by when

The new Trustwide survey 'Your Voice' was launched on 2nd April 2024. The survey will require time to embed therefore we expect to see an increase by Quarter 2

C02 - How was the care we provided?

How was the care we provided?

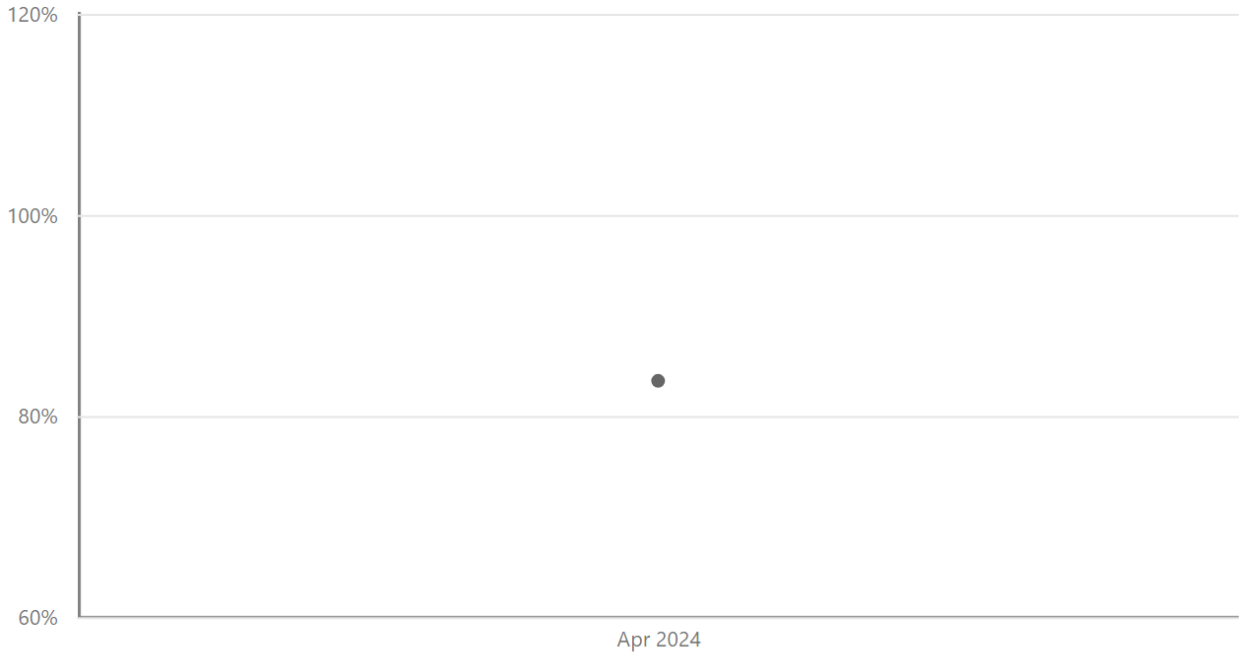
Risk Rating - High (Action)

Performance - 83.5%
Standard - 90.0%

Not Applicable

Not Applicable

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	78.7%	90.0%		
Inpatient Care Group	88.2%	90.0%		
Specialist Care Group	90.4%	90.0%		

Feedback

What the chart tells us

Performance of 83.5% for April was below the standard of 90%

Root Cause of the performance issue

197 people responded to this question, with 162 reporting a good experience of the care provided.

17 people or 9% of respondents reported a poor experience. 7 of these experiences relate to crisis or initial response teams. However, no themes are evident due to the small numbers of associated comments.

Improvement Actions

This continues to be the best performing question for the Trust. Our staff can be considered our best asset for positive experiences of service users and carers.

Expected impact and by when

Ongoing

P01 - Sickness in Month

Percentage of in month sickness absence

Risk Rating - High (Action)

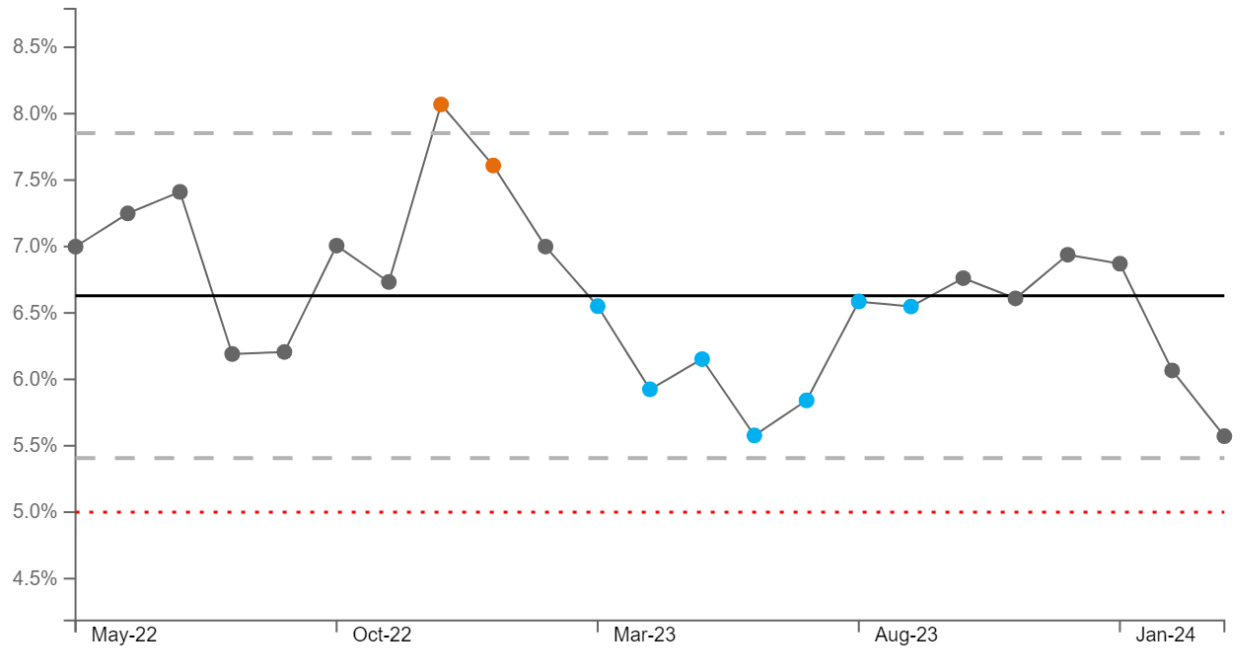
Performance - 5.6%

Standard - 5.0%

Consistently Off target
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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	5.7%	5.0%	Normal Variation	Consistently Fail
Inpatient Care Group	6.4%	5.0%	Improvement	Consistently Fail
Specialist Care Group	6.4%	5.0%	Normal Variation	Consistently Fail
Support & Corporate	2.7%	5.0%	Normal Variation	Consistently Achieve

Feedback

What the chart tells us

The chart shows the confirmed sickness for March 2024 which is reported at 5.6% (excludes NTW Solutions). The provisional sickness for April 2024 is reported at 5.67% remaining above the 5% standard but improving. Without change the standard will not be met.

Root Cause of the performance issue

- Complex home life stressors, caring responsibilities, bereavements.
- Impact of Employee Relations processes – e.g. suspensions and investigations.
- High levels of clinical activity and use of PMVA within working environment,
- Increased demand on Staff Psychological Centre (SPC), delays impacting people staying well at work or being able to return to work.

Improvement Actions

- Continue with robust absent management and people practice processes.
- Promote and continue to implement the health and wellbeing offer.
- Consider and implement reasonable adjustments and flexibility where possible.
- Analysis of absence in new Care Groups to establish themes and trends. Sharing best practice and support mechanisms.
- Groups considering OD interventions and the value of time out. Team Development sessions supporting health and wellbeing.
- Targeted cultural awareness work with support of EDI Lead and Cultural Allies (Mitford).
- Increase attendance by supporting employees to return or remain in work with any adjustments they may require.
- Focus on reducing long term ER cases.

Expected impact and by when

- Predicted absence reduction as previous year trends.

P02 - Training Compliance - Priority Training - All Staff

Training Compliance - Priority Training - All Staff

Risk Rating - High (Action)

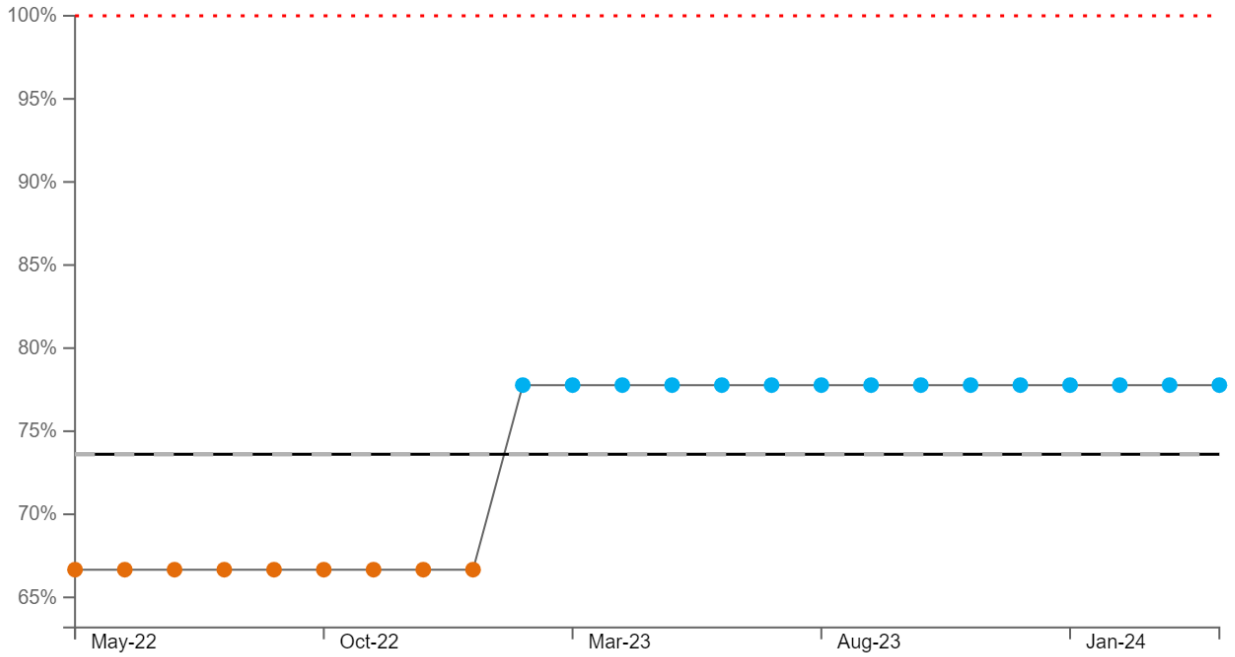
Performance - 77.8%

Standard - 100.0%

Consistently Off target
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



Care Group	Performance	Standard		Variation		Assurance
Other Care Group	77.8%	100.0%		Improvement		Consistently Fail

Feedback

What the chart tells us

Training Compliance for all staff is reported at 77.8% for April 2024. Without change the standard will not be met.

Root Cause of the performance issue

- Capacity to release staff for training
- Late cancellations due to clinical activity
- Cancellation of courses due to trainer availability

Improvement Actions

- Priority training has been agreed within a Training Performance Framework. Includes 53 Corporate and Operational courses with training standards.
- Training working group established to ensure remains organisational focus.
- Continue to improve data quality of needs analysis and who has been trained and not recorded.
- Manage demand and capacity – review offer for all courses and trainers
- Bespoke session planned regarding PMVA within Inpatient Care Group Realign CBU level training trajectory plan following approval of Framework and formation for new Care Groups.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.
- Focus on ensuring IG training is at 95% standard by the end of the financial year

Expected impact and by when

Increase in training compliance in line with set trajectories.

P03 - Training Compliance - Priority Training - Clinical Staff

Risk Rating - **High (Action)**

Training Compliance - Priority Training - Clinical Staff

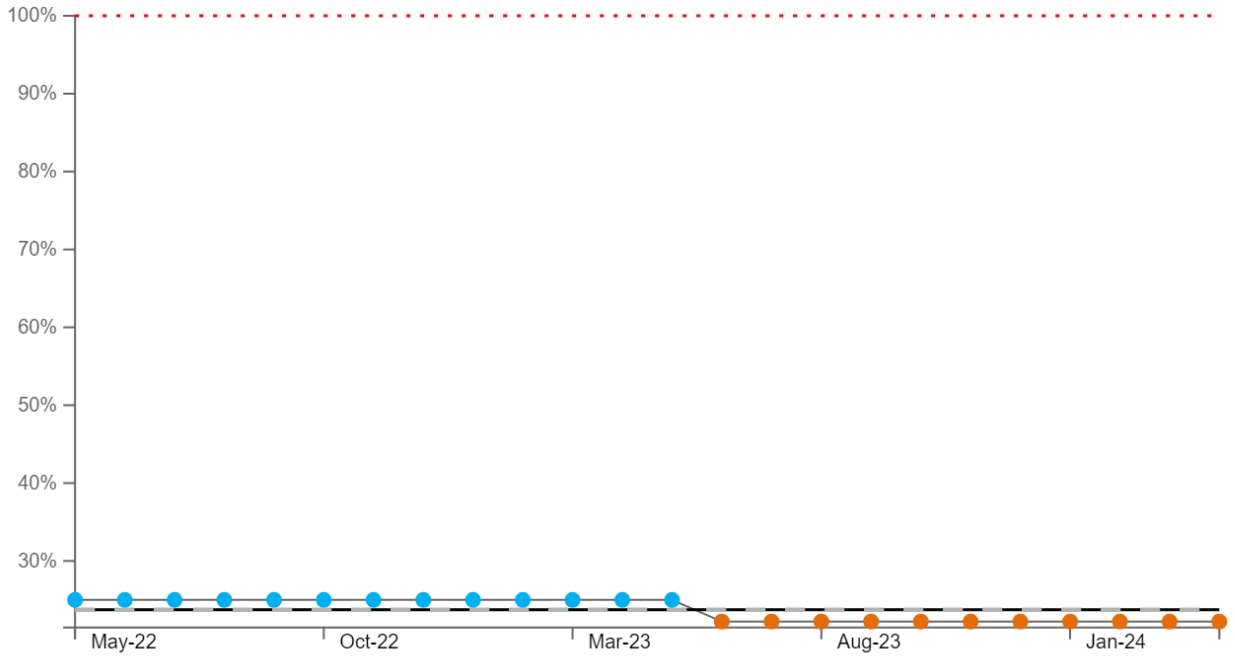
Performance - 22.2%

Standard - 100.0%

Consistently Off target
The standard for this indicator is outside the control limits

Concern
There is concern because this indicator is decreasing

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



Care Group	Performance	Standard	Variation	Assurance
Other Care Group	22.2%	100.0%	Concern	Consistently Fail

Feedback

What the chart tells us

Priority Training Compliance for clinical staff is reported at 22.2% for April 2024. Further work is required on the training data as this percentage currently excludes a number of identified courses.

Root Cause of the performance issue

- Capacity to release staff for training
- Late cancellations due to clinical activity
- Cancellation of courses due to trainer availability

Improvement Actions

- Priority training has been agreed within a Training Performance Framework. Includes 53 Corporate and Operational courses with training standards Training working group established to ensure remains organisational focus.
- Continue to improve data quality of needs analysis and who has been trained and not recorded.
- Manage demand and capacity – review offer for all courses and trainers e.g. PMVA to improve compliance.
- Realign CBU level training trajectory plan following approval of Framework and formation for new Care Groups.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.
- Focus on ensuring IG training is at 95% standard by the end of the financial year

Expected impact and by when

Increase in training compliance in line with set trajectories. Inclusion of remaining six courses.

Great Place to Work - Training

Corporate Training - All Staff

Ref	Indicator Name	Variation	Assurance	Performance	Standard	Numerator	Denominator	Plan	Risk Rating
TA01	Training - Information Governance	Improvement	Consistently Fail	92.0%	95.0%	8447	9182	Internal	Med (Monitoring)
TA03	Training - Local Induction (Once)	Improvement	Consistently Fail	84.1%	87.0%	7700	9154	Internal	Med (Monitoring)
TA04	Training - Safeguarding Adults Level 1	Improvement	Consistently Achieve	96.3%	85.0%	1629	1692	Internal	Low (On Track)
TA05	Training - Safeguarding Children Level 1	Improvement	Consistently Achieve	95.6%	85.0%	1618	1692	Internal	Low (On Track)
TA06	Training - Fire	Improvement	Achieve at Random	89.0%	85.0%	8168	9182	Internal	Low (On Track)
TA07	Training - Equality & Diversity Introduction	Improvement	Consistently Achieve	95.1%	85.0%	8734	9182	Internal	Low (On Track)
TA08	Training - Health & Safety	Improvement	Consistently Achieve	94.3%	85.0%	8658	9182	Internal	Low (On Track)
TA09	Training - IPC	Improvement	Consistently Achieve	92.4%	85.0%	8482	9182	Internal	Low (On Track)
TA10	Training - Moving & Handling Awareness Training	Improvement	Consistently Achieve	93.5%	85.0%	8588	9182	Internal	Low (On Track)

NB: PSIRF, Corporate Governance and Risk Management Training to be added for the next IPR. Local induction is a trajectory of 87% for Q1, the standard to be met for Q4 is 95%

Operational Staff Training

Ref	Indicator Name	Variation	Assurance	Performance	Trajectory	Numerator	Denominator	Plan	Risk Rating
TC01	Training - Clinical Risk and Suicide Prevention	Normal Variation	Achieve at Random	75.2%	76.0%	2361	3138	Internal	Med (Monitoring)
TC03	Training Resuscitation L2 Adult Basic Life Support	Improvement	Consistently Fail	72.9%	73.0%	1285	1762	Internal	Med (Monitoring)
TC04	Training Resuscitation L3 Adult Immediate Life Supp	Improvement	Consistently Fail	62.1%	64.0%	2242	3610	Internal	Med (Monitoring)
TC05	Training Resuscitation L3 Paediatric Immed Life Supp	Improvement	Consistently Fail	9.9%	24.0%	30	304	Internal	High (Action)
TC06	Training Resuscitation L2 Paediatric Basic Life Supp	Improvement	Consistently Fail	66.1%	65.0%	397	601	Internal	Med (Monitoring)
TC07	Training - PMVA Basic	Improvement	Consistently Fail	67.7%	68.0%	1789	2642	Internal	Med (Monitoring)
TC09	Training - Engagement & Observation (3 years)	SPC N/A		78.5%	78.0%	2643	3365	Internal	Low (On Track)

NB: Dysphagia Awareness and Risk Tool training to be added for the next IPR. These all have Standards of 85% but trajectories to achieve this over the course of the year

P04 - Appraisal rate

Appraisal rate

Risk Rating - **High (Action)**

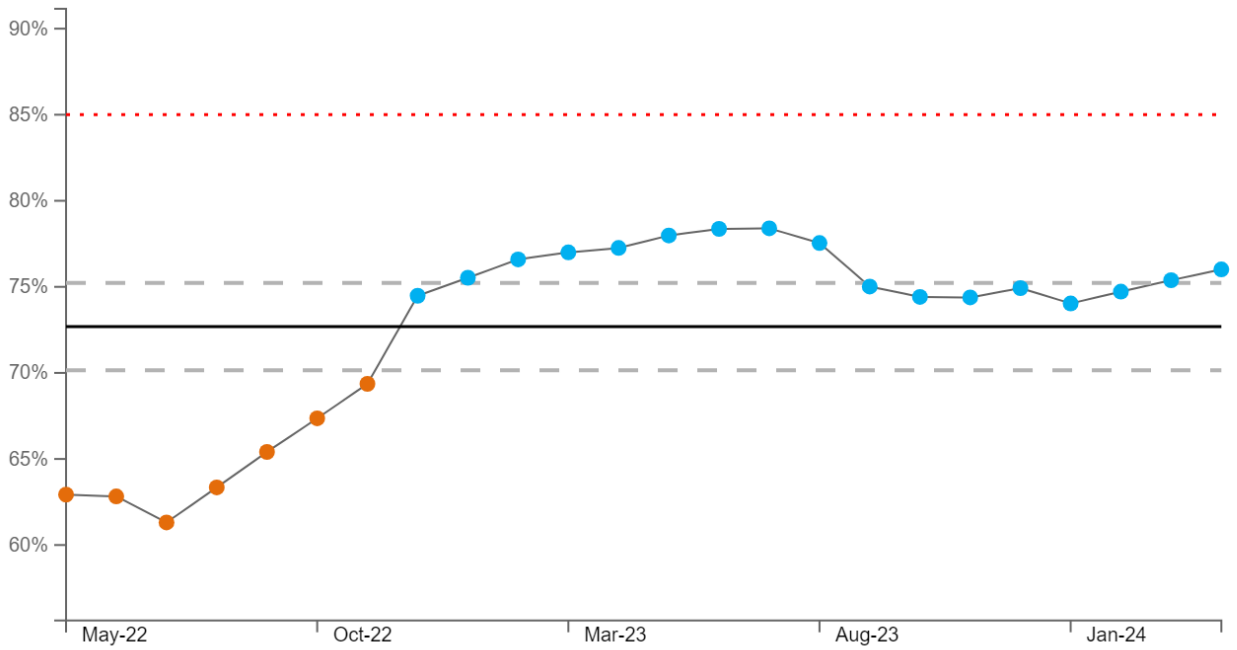
Performance - 76.0%

Standard - 85.0%

Consistently Off target
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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	79.6%	85.0%	Improvement	Consistently Fail
Inpatient Care Group	74.9%	85.0%	Improvement	Consistently Fail
Specialist Care Group	74.9%	85.0%	Normal Variation	Consistently Fail
Support & Corporate	68.8%	85.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

The reported appraisal rate for April is 76.0% (now excludes NTW Solutions), the seventeenth consecutive month reported higher than the mean average, though it remains below the 85% standard. Without change the standard will not be met.

Root Cause of the performance issue

- Capacity to prepare and undertake appraisal
- Late cancellations due to clinical capacity
- Pressure around other training compliance

Improvement Actions

- Promotion through CBU meetings and Workforce Triage; discuss capacity and appropriate support, delegation where appropriate, forward planning.
- Working towards embedding and promotion of regular appraisal / supervision discussion, ensuing value within discussions.
- Proactively booking appraisals and setting protected time.
- Informing career and talent conversations, leading to development and investment in sustainability of workforce.
- Meaningful discussions with staff.
- A full review of the Appraisal process and documentation is underway to align to the delivery of ESR project timescales.

Expected impact and by when

- Increase in appraisal compliance in line with set trajectories over 24/25.

P05 - % Clinical Supervision completed

Clinical Supervision

Risk Rating - **High (Action)**

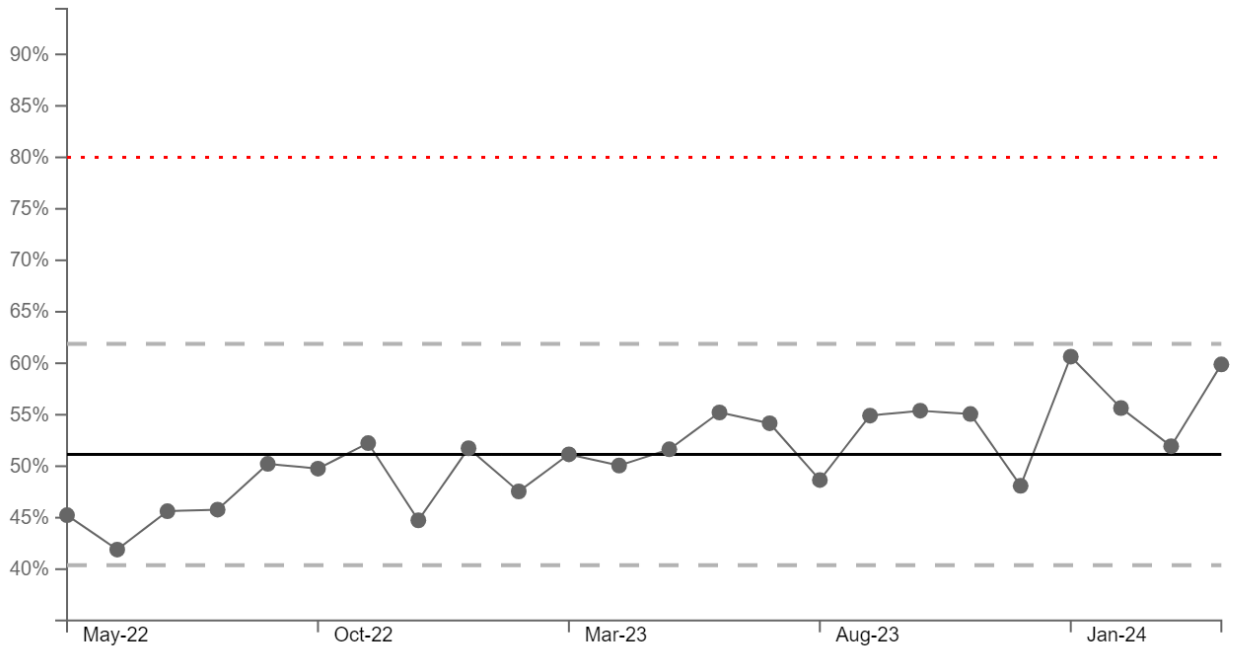
Performance - 59.9%

Standard - 80.0%

Consistently Off target
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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	68.4%	80.0%	Normal Variation	Consistently Fail
Inpatient Care Group	52.5%	80.0%	Normal Variation	Consistently Fail
Other Care Group	22.6%	80.0%	Concern	Consistently Fail
Specialist Care Group	58.8%	80.0%	Normal Variation	Consistently Fail
Support & Corporate	60.8%	80.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Performance of 59.9% in April is within the expected range but remaining well below the 80% standard. Without change the standard will not be met.

Root Cause of the performance issue

- Capacity to release staff to undertake supervision
- Late cancellations due to clinical capacity
- Recording of supervision taking place doesn't happen in the electronic system

Improvement Actions

- Supervision rate monitored through local Clinical Management Teams, Quality Standards and Oversight meetings within CBU's.
- Setting expectations with CBU leadership team.
- Establishing and escalating any recording and data issues.
- Forward planning - supervision to be pre-booked in advance to ensure that it remains a priority.
- Live supervision to be recorded appropriately.

Expected impact and by when

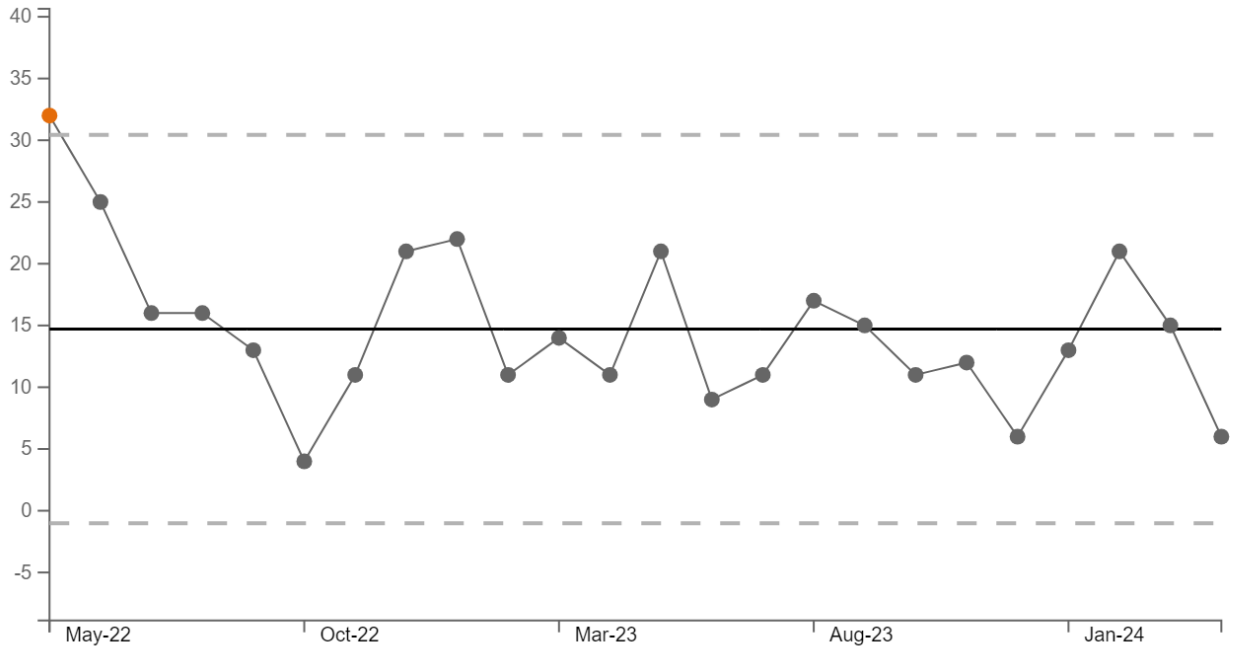
- Increase in appraisal compliance in line with set trajectories over 24/25.

Q01 - MRE Restraints

Number of MRE Restraints

Risk Rating - Med (Monitoring)

Performance - 6	N/Ap	Normal Variation	DQ - No Concern
Standard N/Ap	Assurance cannot be given for this indicator as there is no standard set	The variation for this indicator is within the control limits	There are currently no concerns with the data quality of this indicator



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	1	No Std	Normal Variation	No Standard
Specialist Care Group	5	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 6 MRE restraints reported in April 2024.

Root Cause of the performance issue

- MRE restraint is required when a patient is at very high to themselves or others. This is usually during transfer to and acute hospital for emergency care. It can be dignified if used appropriately, but the aim is to only use it when necessary.

Improvement Actions

- Focussed workshops have taken place within CYPS and LDA pathways , groups have produced action plans which are in place
- Work will be ongoing to ensure MRE use continues to reduce whilst maintain patient and staff safety.
- Following the workshop it was agreed that MRE restraint would only be used for transfer to acute hospital in circumstances that were absolutely necessary and following sign off.

Expected impact and by when

Continued reduction

Q02 - Prone Restraints

Number of Prone Restraints

Risk Rating - Med (Monitoring)

Performance - 51

Standard N/Ap

N/Ap

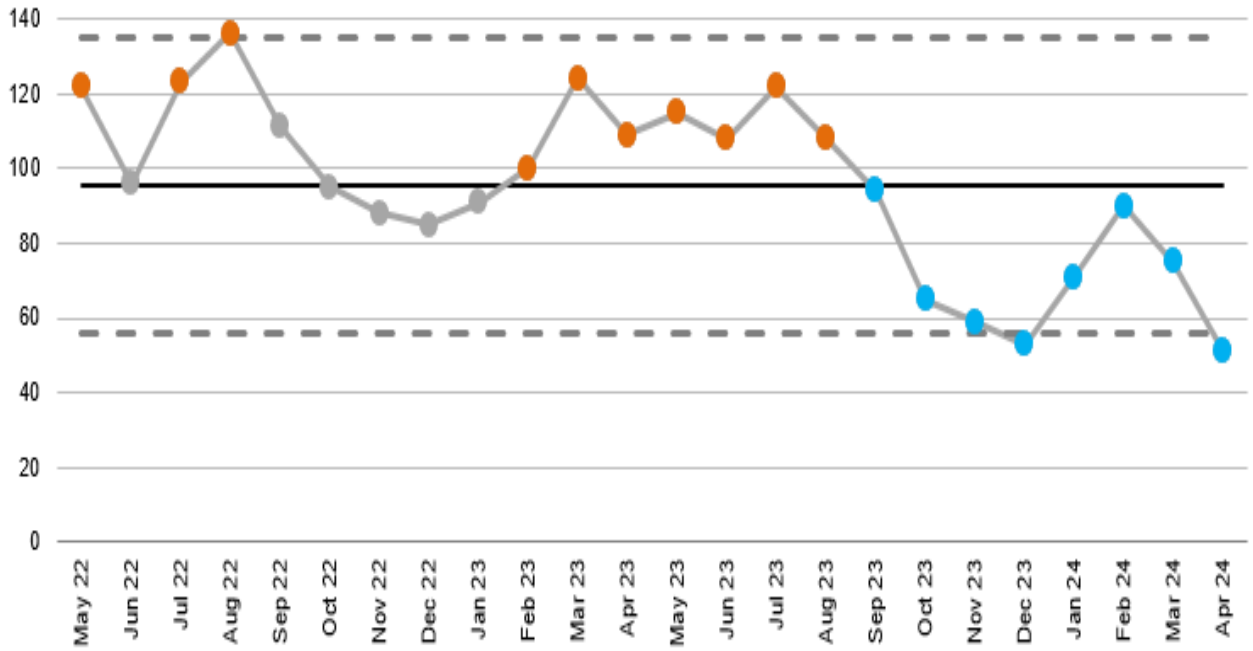
Assurance cannot be given for this indicator as there is no standard set

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



A breakdown of the reporting for the IPR is being developed

Feedback

What the chart tells us

There were 51 Prone restraints reported in April and there has been a statistically significant reduction in the use of prone restraint.

Root Cause of the performance issue

- Within the Inpatient Care Group, the Older Peoples pathway accounted for the highest number of restraints in the period (47% of all incidents). There is one outlier Older Peoples ward which accounted for 42% of all OP restraints (of which one patient account for 82% of the wards restraint incidents - this reflects the complexity of the patient's diagnosis and the need to support their hygiene and care multiple times per day).

Improvement Actions

- Increased emphasis on safer alternatives to prone restraint have been maintained across both the Positive and Safe Team and PMVA tutors
- Mitford has started to reduce prone restraint within that unit due to focussed work
- The Trust has maintained a significant downward trend in the use of prone restraint across 23-24(excluding Mitford)

Expected impact and by when

Continued reduction will be monitored

Q03 - Long term segregation and prolonged seclusion

Risk Rating - Med (Monitoring)

Long term segregation and prolonged seclusion of 48 hours or longer calculated at the end of the seclusion

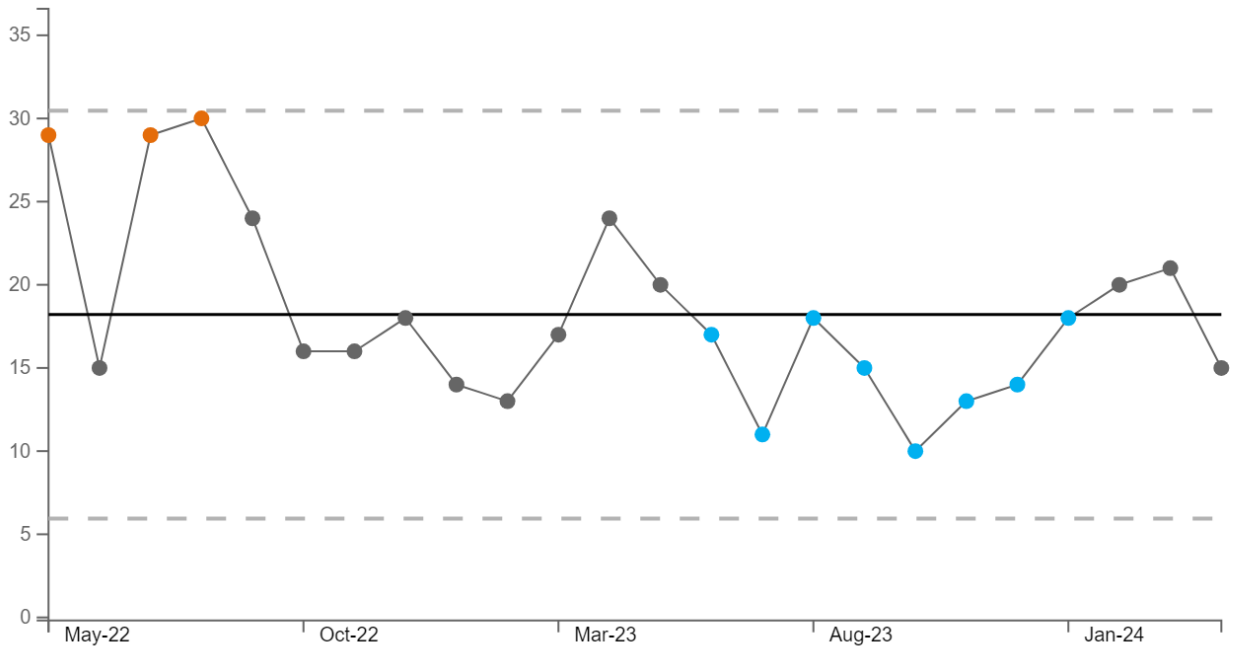
Performance - 15

Standard N/Ap

N/Ap
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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	10	No Std	Normal Variation	No Standard
Specialist Care Group	5	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 15 reported in April 2024.

Root Cause of the performance issue

- A decline in its use has been noted , however the panel are aware that this may rise in the near future due to a small number of patients being initiated this month.

Improvement Actions

- The Long-term segregation panel continues to review patients subject to long term segregation and pro longed seclusion on a weekly basis.

Expected impact and by when

Continued reduction

Q04 - Assaults on Patients

Number of Assaults on Patients

Risk Rating - Med (Monitoring)

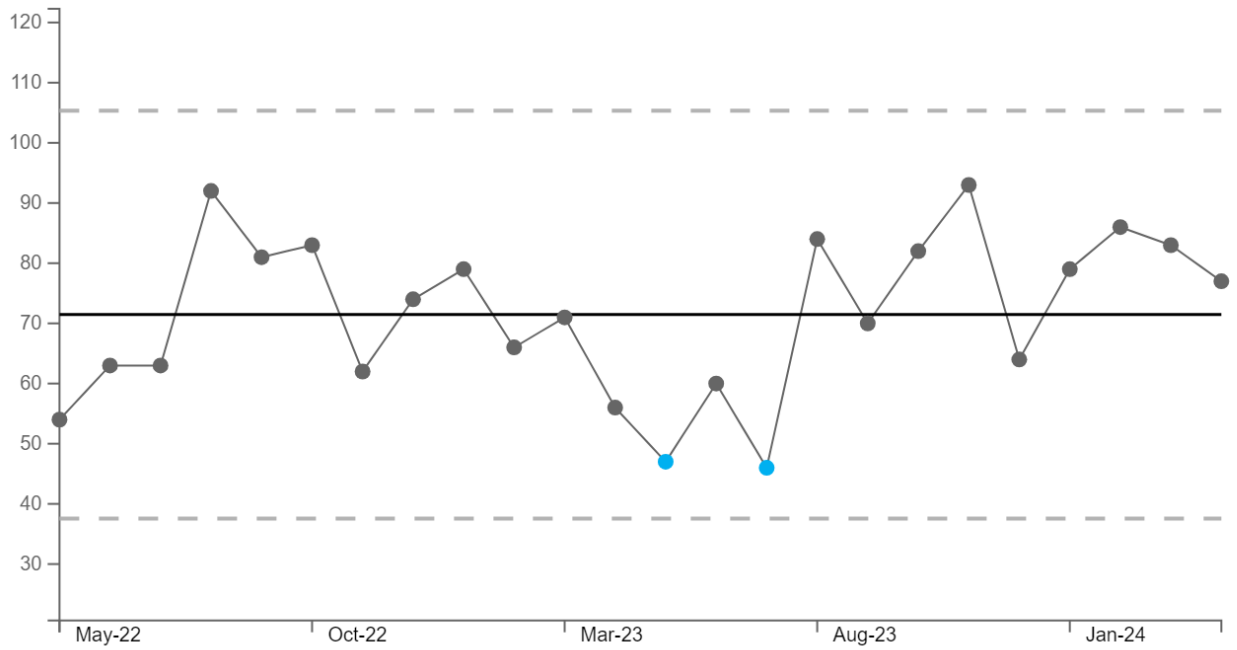
Performance - 77

Standard N/Ap

N/Ap
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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	7	No Std	Normal Variation	No Standard
Inpatient Care Group	62	No Std	Normal Variation	No Standard
Specialist Care Group	8	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 77 recorded incidents of assaults on patients during April which falls within the calculated expected range of 38 and 105. Whilst we have seen a rise in assaults since December, the data indicates the numbers have dropped in the last quarter.

Root Cause of the performance issue

- Physical assaults between patients most commonly occurs on female acute admission wards and older people's wards, children's or autism services , which regularly features in all aggression and violence data doesn't appear in the top 10 of services. This is likely due to the levels of staffing and care planning and potential separation of patients.
- April's figure of 77 assaults is higher than the previous April ,but in line with a general incident reporting increase. Most incidents are reported as no or low physical harm.
- Within the Inpatient Care Group, the Acute pathway accounted for the highest number of assaults on patient in the period (66% of all incidents). No clear outlier evident in month (no one patient accounted for more than 10% of all assaults on patient).

Improvement Actions

- When incidents of assault between patients are reported clinical teams will frequently escalate the incident for review by the Safeguarding Team due to vulnerability of both parties , for further advice and support. This activity will be considered in the new aggression and violence group when it meets.

Expected impact and by when

As part of full review of data at the aggression and violence group.

Q05 - Assaults on staff

Number of Assaults on staff

Risk Rating - Med (Monitoring)

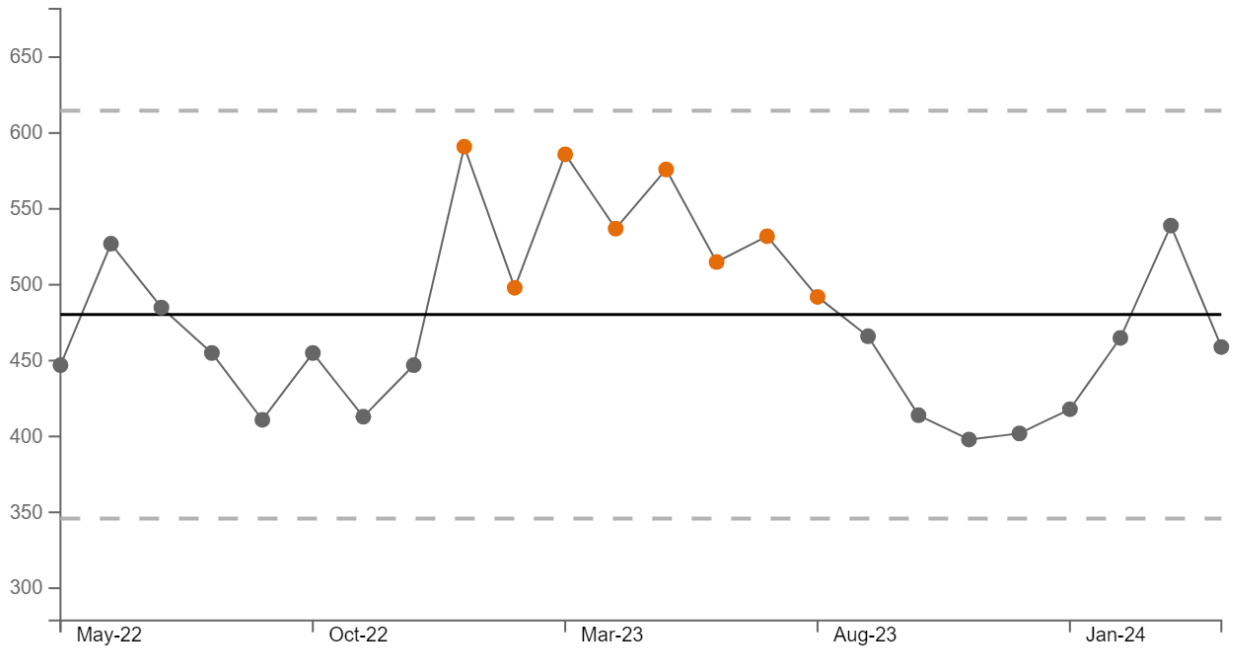
Performance - 459

Standard N/Ap

N/Ap
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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	7	No Std	Normal Variation	No Standard
Inpatient Care Group	224	No Std	Normal Variation	No Standard
Specialist Care Group	227	No Std	Normal Variation	No Standard
Support & Corporate	1	No Std		No Standard

Feedback

What the chart tells us

There were 459 recorded incidents of assaults on staff during April which falls within the calculated expected range of 349 and 610. Whilst we have seen a decrease in assaults through 2023 , but started to rise again in January 2024 and April is the first time since then that it has reduced. Further evaluation of violence and aggression will be a key part of the new V&A sub group of Trust wide Safety.

Root Cause of the performance issue

- Physical assaults on staff is a significant focus of the organisation following our response to the HSE Improvement notice. The improvements, controls and support arrangements continue to remain in place in relation to Mitford with Executive Director oversight.
- Within Inpatient care Group the Older Peoples pathway accounted for the highest number of assaults on staff in the period (38% of all incidents). There is one outlier Older Peoples ward which accounted for 45% of all staff assaults in Older People wards (of which one patient account for 49% of the assaults on the ward - the number of assaults related to this patient has decreased as the ward gain greater understanding into their diagnosis and triggers).

Improvement Actions

- Due to the focus on care planning and other safety systems reviews assaults on staff is significantly lower than the previous April with about a 19% reduction, a number of actions have been identified around MDT review, This has resulted in a significant reduction in moderate physical harm incidents as well of the 459 assaults , 441 were reported as no or low physical harm. Form the incidents reported in April only 8 were reported to the HSE under RIDDOR reporting requirements and all related to over 7 day absence from work.. This information is now being reported weekly to Trust-wide Safety Group so that the organisation is more sighted staff related harm from specific incidents.

Expected impact and by when

The new aggression and violence group which is due to meet in June 2024 , will review as part of its terms of reference all aspects of safety that impact on assaults on staff and implement further measures.

Q06 - % of patients with a Safety Plan

% of patients with a Safety Plan

Risk Rating - Med (Monitoring)

Performance - 76.1%

Standard - 100.0%

Not Applicable

Not Applicable

DQ - No Concern

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

Care Group	Performance	Standard	Variation	Assurance
Community Care Group	75.6%	100.0%		
Inpatient Care Group	73.6%	100.0%		
Specialist Care Group	79.6%	100.0%		
Support & Corporate	74.2%	100.0%		

Feedback

What the chart tells us

In April 76.1% of patients were reported to have a safety plan.

Inpatient services – 86.4% (76 out of 88)

Community – 75.9% (4,391 out of 5,783)

Root Cause of the performance issue

- The new risk framework form went live on 15th April 2024. Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards.

Improvement Actions

- Embedding the framework
- Data quality report is being monitored by the Steering group
- New Risk policy is currently in progress
- A review of the metric methodology is due to take place in June 2024
- Evaluation of the framework is under development

Expected impact and by when

Ongoing as framework is being embedded

Q08 - Rights at Point of Detention

Risk Rating - Med (Monitoring)

Number of clients (Detained) whose detention has started within the reporting period and there is a Record of Rights Given (detained/CTO) - Form H3L within 7 days either side of the detention starting

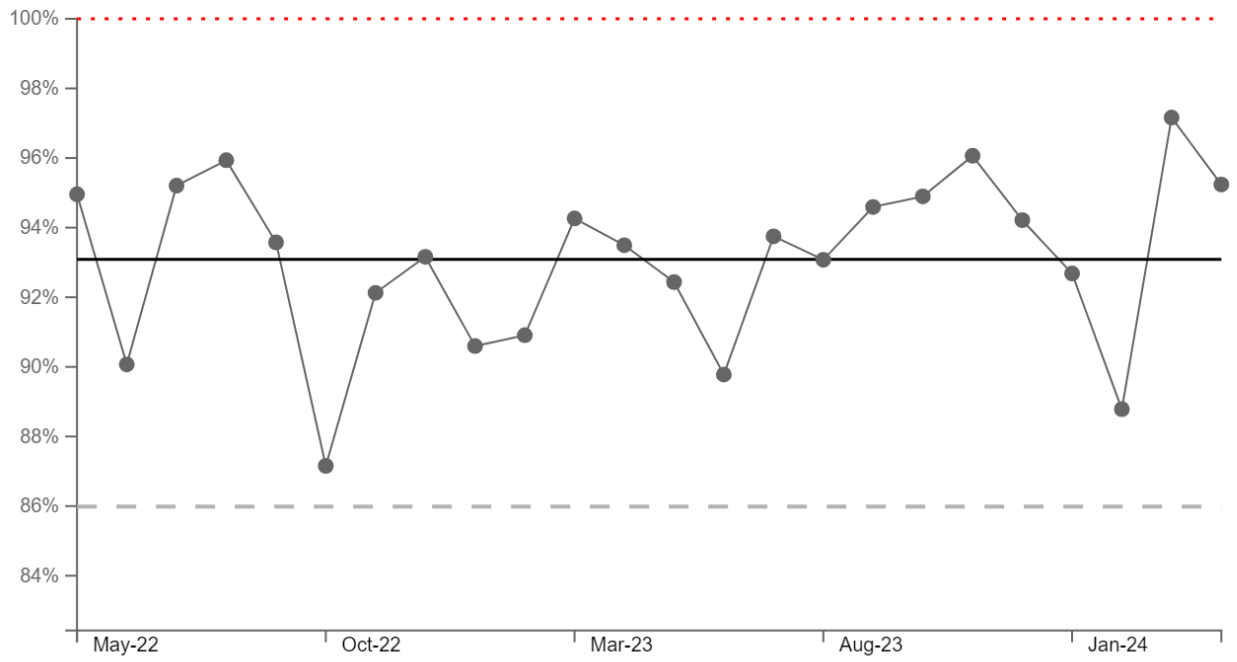
Performance - 95.2%

Standard - 100.0%

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

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

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	94.9%	100.0%	Normal Variation	Achieve at Random
Specialist Care Group	100.0%	100.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Compliance in this area continues to fluctuate and is reported for April at 67.6%.

Root Cause of the performance issue

- New nursing staff on the ward who are not aware of our duty to give a person their rights when detained and the requirement to review rights.

Improvement Actions

- Rights on a page poster circulated to all wards to remind nursing staff of our duty to provide patients with their rights when detained under the MHA 1983 in accordance with section 132 and when to revisit rights.
- Nursing staff to continue carry out MHA weekly/monthly checks on aspects of MHL including the monitoring of ensuring patients have been given their rights within 7 days of being detained under the MHA.
- Nursing staff to continue the monitoring of the ward at glance boards to ensure rights are given within 7 days of detention
- MHL Specialist to attend the quality standards groups for inpatients and community to report on compliance on the giving of rights at the point of detention.
- MHL Training to focus on section 132 to educate nursing staff about the giving of rights and the important role that they have to ensure patients can exercise their right to appeal when detained under the MHA.
- Patients rights awareness e learning package to be implemented. The learning package will include interactive session

Expected impact and by when

We would expect to see impact from the actions by the end of quarter 3.

Q09 - Record of Capacity/ CTT at point of detention

Risk Rating - **High (Action)**

Number of Clients with a Record of Capacity/CTT for Detained Clients forms with Part A completed within 7 days either side of the 3 Month Rule starting date.

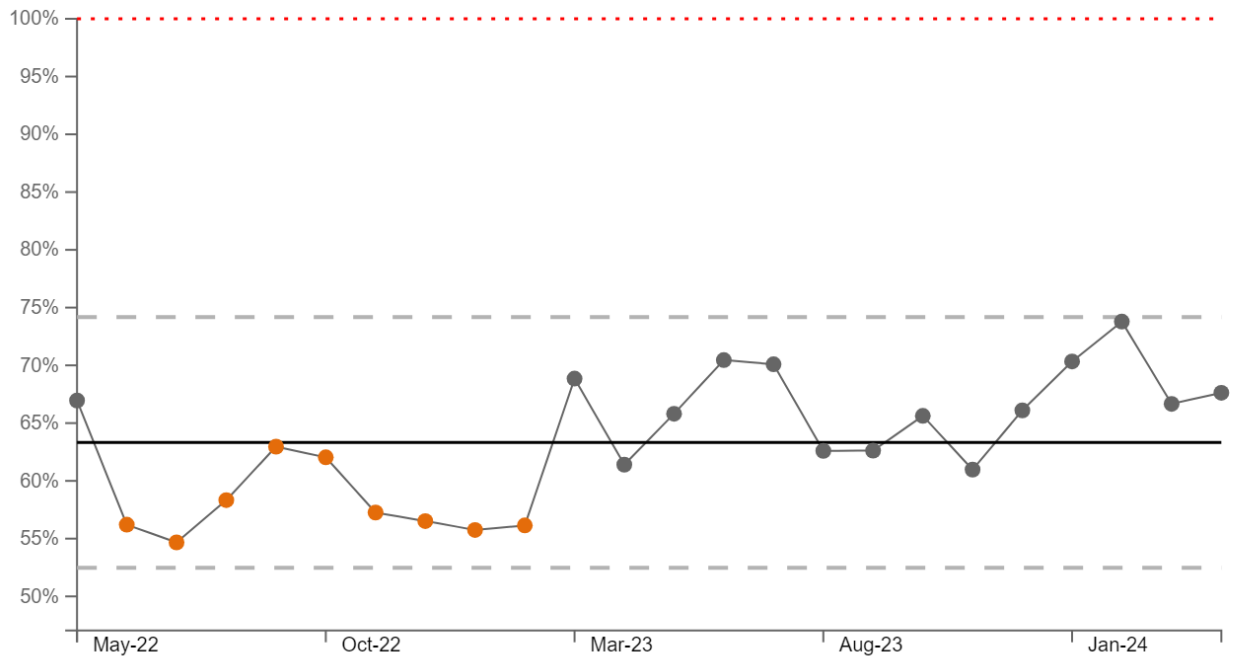
Performance - 67.6%

Standard - 100.0%

Consistently Off target
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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	70.3%	100.0%	Normal Variation	Consistently Fail
Specialist Care Group	36.4%	100.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

April compliance is reported at 67.6% for the completion of the local form Part A Record of Capacity/CTT, significant improvement is required across the Trust.

Root Cause of the performance issue

- Lack of awareness on the requirement to complete this form
- 7 day timeframe not sufficient time for Responsible Clinicians to complete the form

Improvement Actions

- Group Directors for each locality have been tasked to look at different ways to improve compliance.
- In the Mental Health Legislation Steering Group (MHLSG) it was recommended that an audit on the consent to treatment provisions within the Act is carried out in 2024/2025 by internal audit. The outcome and recommendations from this audit will highlight to the groups what actions are required for improvements to be made.
- Following the MHLSG on 25 April a working group was formed to review the local form to look at any barriers in the completion of the form and to remove those barriers.
- MHL Specialist to attend the quality standards groups for inpatients and community to report on compliance around record of capacity at point of detention.

Expected impact and by when

- We would expect to see impact from the actions by the end of quarter 3.

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

Bed Occupancy including leave (open beds on RiO)

Risk Rating - **High (Action)**

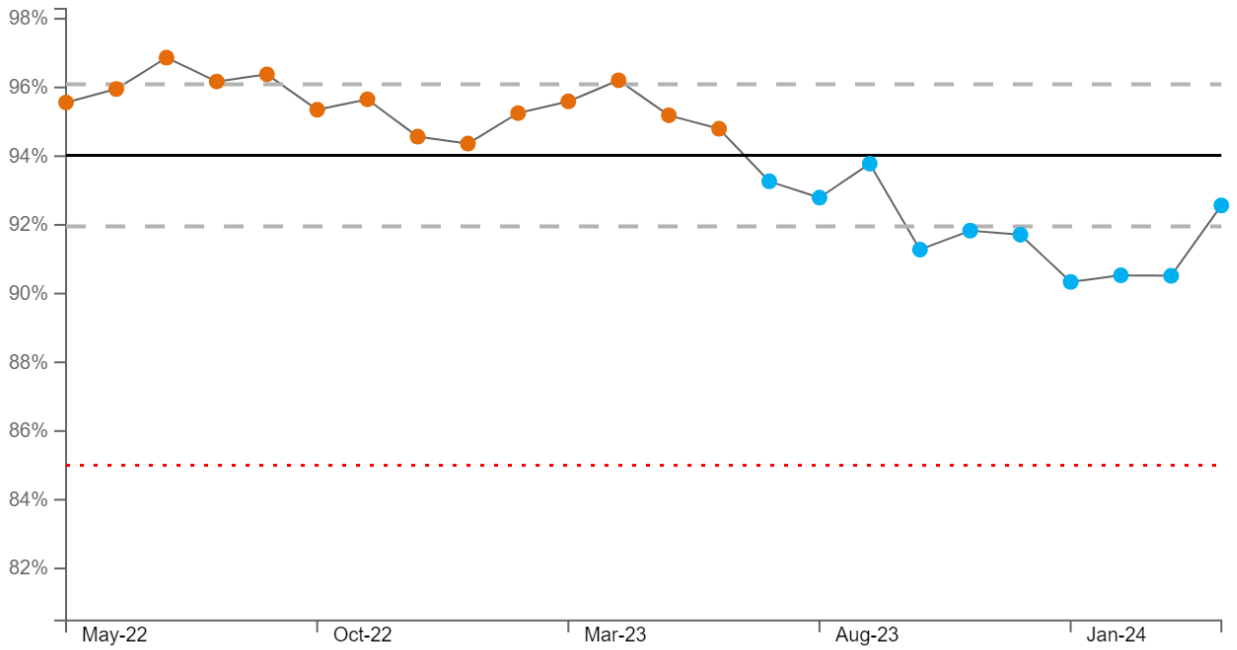
Performance - 92.6%

Standard - 85.0%

Consistently Off target
The standard for this indicator is outside the control limits

Improvement
This indicator is decreasing which shows improvement

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	100.8%	85.0%	Normal Variation	Consistently Fail
Other Care Group	0.0%	85.0%	Improvement	Achieve at Random
Specialist Care Group	79.8%	85.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Bed occupancy was at 92.6% in April and remains higher than the optimal level of 85%.

Root Cause of the performance issue

- Within Autism Inpatients there remains a pause in referrals (for 6 months from January 24). Mitford Bungalows remains empty in terms of beds until the review work is concluded.
- Reporting is based on open beds on Rio, beds may be left open and included in reporting affecting occupancy levels.
- Bed availability in line with national performance and pressures. Some beds are temporarily unavailable. Unable to discharge patients who are clinically ready for discharge due to other pressures outside CNTW.

Improvement Actions

- Enhanced Bed Management discharge facilitators support wards and are attached to each locality for consistency. The localities work closely with enhanced bed management to try and ensure the locality leadership team have oversight and influence around acuity and level loading.
- Implementation of admission and discharge policy. System wide working with third sector.
- There is significant oversight of the beds currently out of use.
- Review open beds on Rio to ensure accurate reporting.

Expected impact and by when

It is predicted bed occupancy will remain above the optimal level of 85% but the actions above will maintain bed occupancy.

A03 - % Adult inpatients discharged with LOS > 60 days

Risk Rating - Med (Monitoring)

Number of adult inpatients discharged during the reporting period with length of stay > 60 days (Q&P Metric 2427)

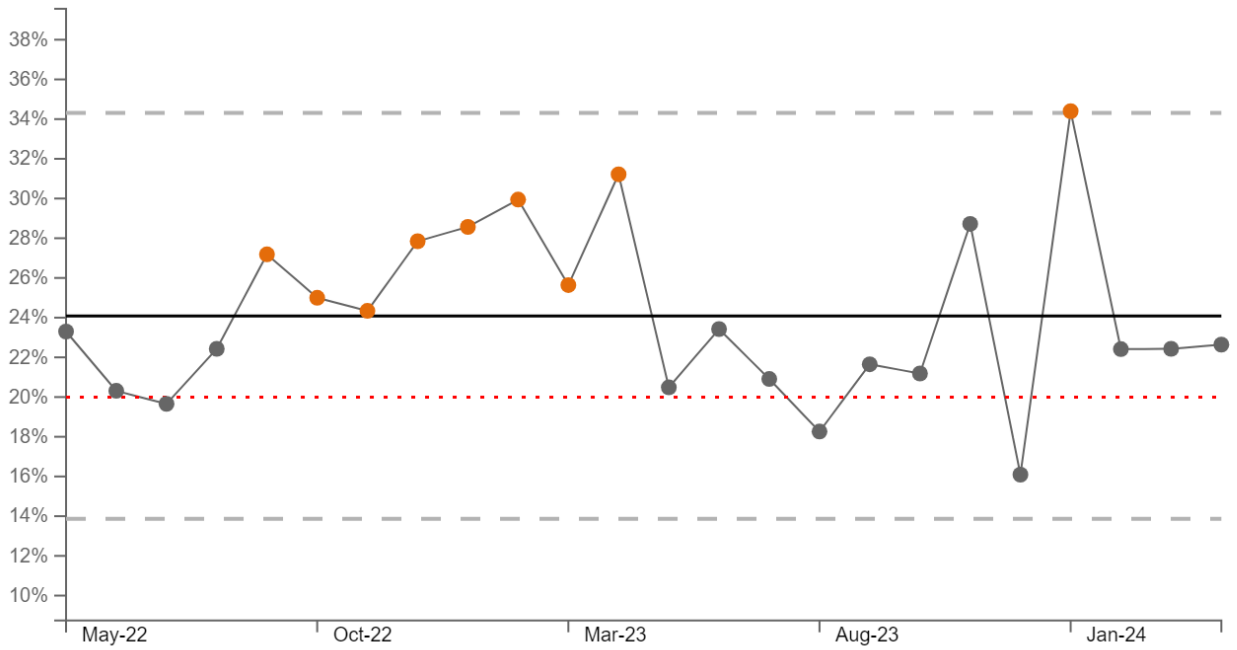
Performance - 22.6%

Standard - 20.0%

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	21.9%	20.0%	Normal Variation	Achieve at Random
Specialist Care Group	100.0%	20.0%	Concern	Consistently Fail

Feedback

What the chart tells us

In April 22.6% of patients were discharged where the length of stay exceeded 60 days. Data relates to adult acute wards within the inpatient care group and Gibside ward within the specialist care group.

Root Cause of the performance issue

- Patient inpatient spells are longer than 60 days, contributing factors include, patients admitted for differing reasons tend to spend longer in hospital, as do individuals with more complex clinical needs. Wider system factors are also impacting LOS, inefficiencies in patient flow, caused by, for example, delays in discharge. This is in the context of high bed use capacity, vacancies and the availability of alternatives in discharge in housing and social care, as such not all factors influencing of LOS are controlled by the group, however we are working to influence wider decision making.

Improvement Actions

- Red to Green days implemented
- Focus on patient discharge from admission
- Meeting are in place with the local authorities to review CRDFs
- Key Lines of Enquiry exercise is underway across inpatients
- Daily huddles are underway.
- Refreshed governance and oversight of factors contributing to LOS are embedding.

Expected impact and by when

It is expected that LOS will improve over summer 2024.

A05 - Clinically Ready for Discharge (formerly DTOC)

Risk Rating - High (Action)

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

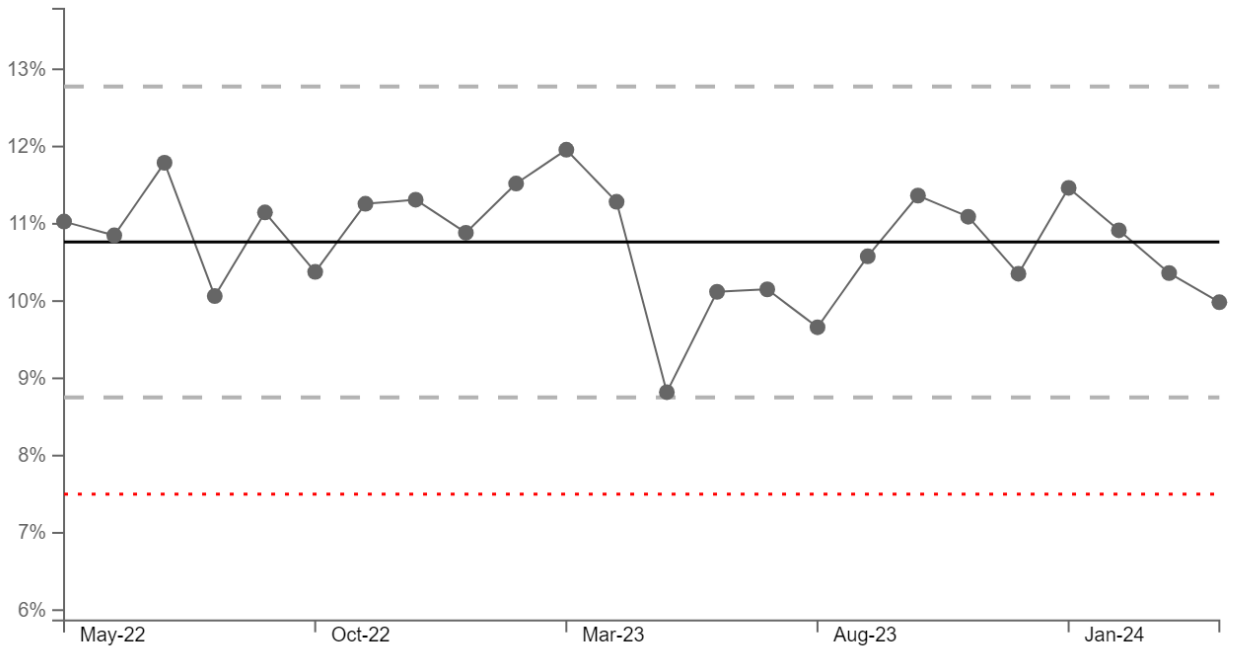
Performance - 10.0%

Standard - 7.5%

Consistently Off target
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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	10.4%	7.5%	Normal Variation	Consistently Fail
Specialist Care Group	8.3%	7.5%	Improvement	Achieve at Random

Feedback

What the chart tells us

In April 10.0% of patients were clinically ready for discharge. Within CYPS 23.5% were recorded as clinically ready for discharge (excluded from this metric). Without change the standard will not be met

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.
- Dedicated focus by senior case manager to review and support discharge plans for those CRFD
- Fortnightly CRFD meetings with Local Authority and Place based ICB.
- Daily flow meetings.
- Home Group contract in the North for Northumberland residents extended to end of Q1 24/25. With commitment to further extend to March 24/25 through BCF monies.

Expected impact and by when

It is anticipated that CRFD will remain above the optimal level of 7.5% but the actions above are supporting and maintaining performance within the expected range.

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

Risk Rating - **High (Action)**

% 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

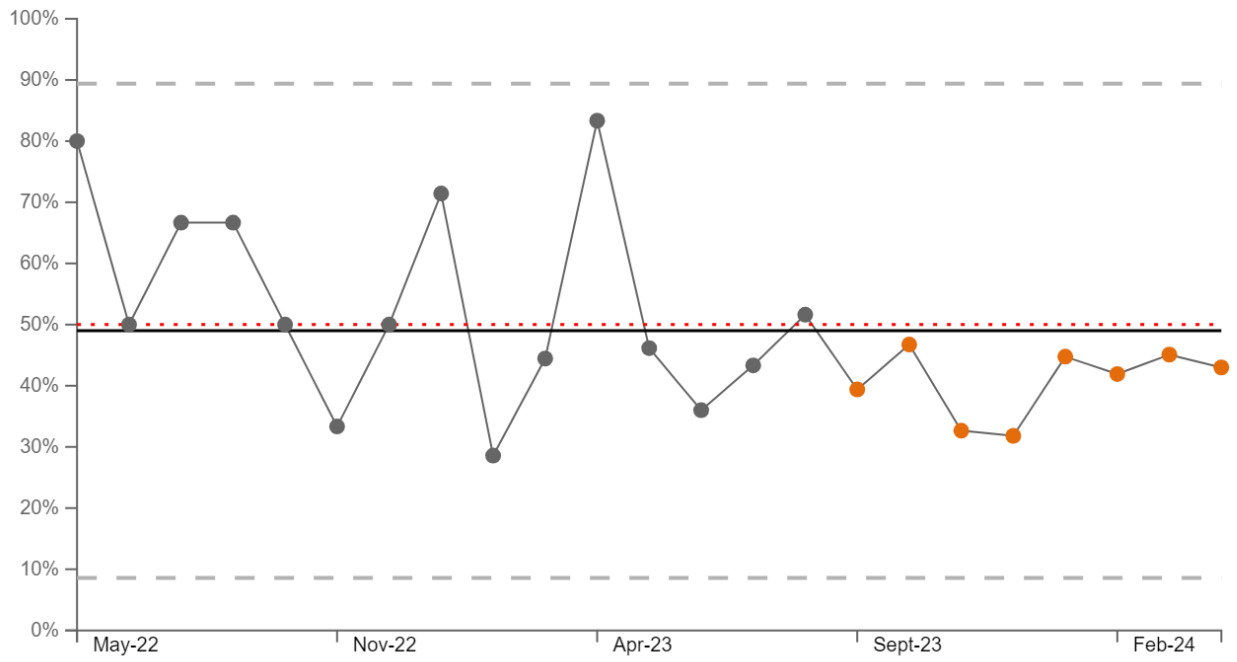
Performance - 43.0%

Standard - 50.0%

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

Concern
There is concern because this indicator is decreasing

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



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	35.0%	55	157	50.0%	Concern	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	61.9%	13	21	50.0%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	66.7%	24	36	50.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Very urgent referrals seen within 4 hours achieved 43.0% in April

Root Cause of the performance issue

- Inconsistencies across locality in Very Urgent referral recording and accuracy of contact recording.
- Staffing shortages particularly with Band 6s.
- High level of clinical activity.
- Data quality input issues:.

i. Duplicate referrals opened to teams.
ii. Appointments outcomes not being complete.
iii. Appointments not being put in Rio diaries.
iv. Referrals opened incorrectly (72hrs & 136 suite)

- 136 staffing model and the impact on the crisis service.

Improvement Actions

- Consideration for process when high levels of temporary staffing are used to support capacity to ensure methodology continues to be followed.
- Peer review of referrals urgencies via Access Oversight sub-group
- Standardisation of referral recording, through Access Oversight sub-group
- Staff supported to correct data quality issues

Expected impact and by when

Expected continued improvement across Quarter 1 2024.

A08 - % PLT ED Referrals seen within 1 hour

Risk Rating - Med (Monitoring)

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

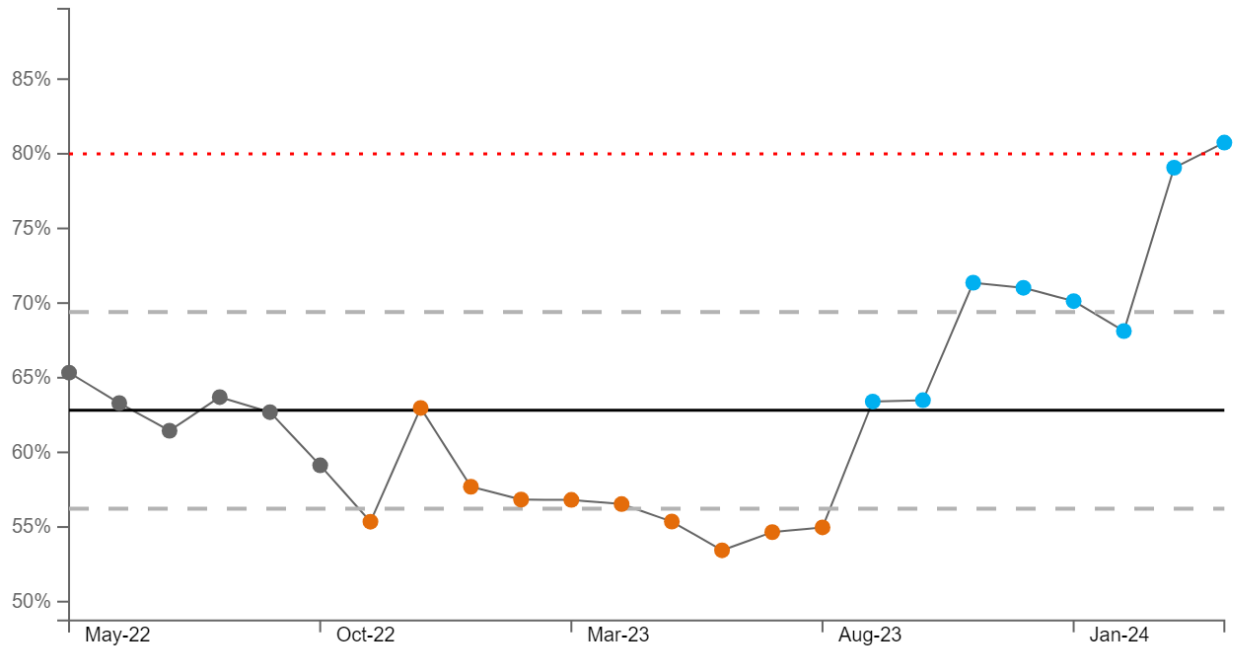
Performance - 80.8%

Standard - 80.0%

Consistently Off target
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



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	78.0%	287	368	80.0%	Improvement	Consistently Fail
North Cumbria & Northumberland & North Tyneside Place Team	72.2%	285	395	80.0%	Improvement	Consistently Fail
Sunderland & South Tyneside Place Team	95.1%	292	307	80.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Performance was 80.8% in April which is above the expected range and the highest performance reported within 24 months.

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 the target.
- Staffing (recruitment/retention/sickness) remains a challenge when organising cover.
- PLT not resourced sufficiently to provide 24/7 1hr response when clinical demand is high.
- Staffing pressures due to increased short term absence
- Geography of community hospital with North Locality

Improvement Actions

- Place Teams are reviewing breach reports weekly to support any potential data quality issues
- Additional training provided to staff
- Access Oversight sub-group recording guidance has been rolled out to support improvement in data quality (live 20th March 2024).
- Dedicated operational management within the service is now supporting practice review and improvement work.
- Ongoing work within PLT re service specifications and commissioned resource in relation to current demand.
- Ongoing work with the Acute Trust in relation to the referral point

Expected impact and by when

Performance is improving with all areas reporting an improvement

A10 - % 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)

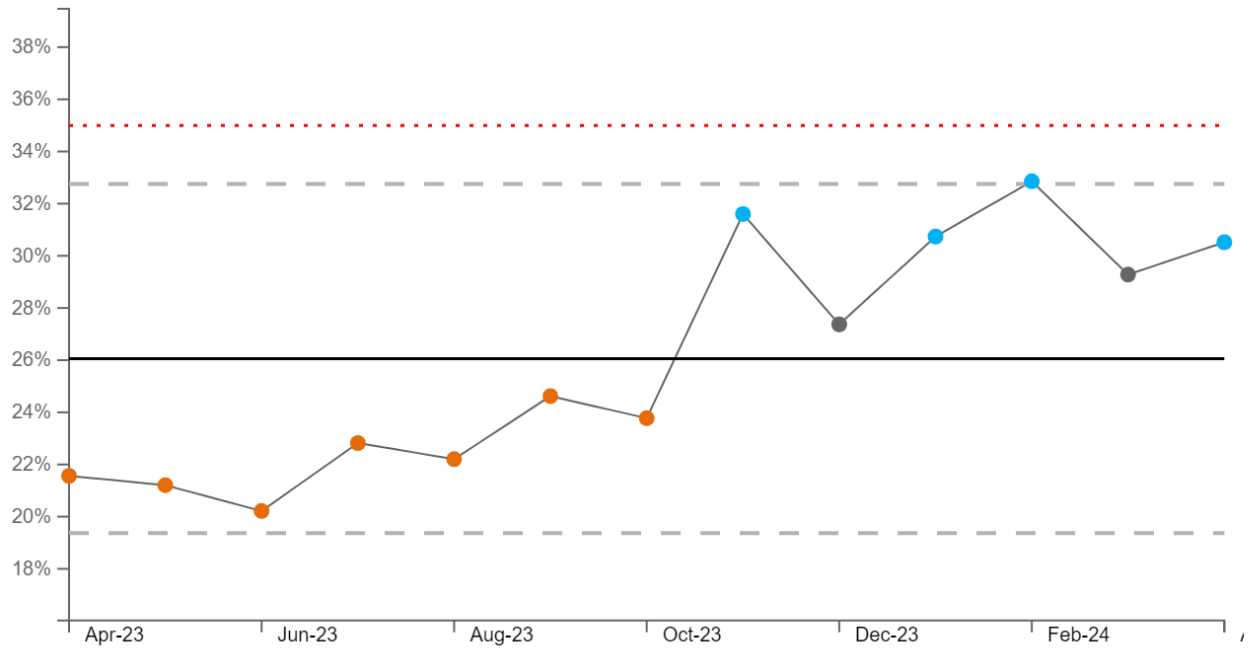
Performance - 30.5%

Standard - 35.0%

Consistently Off target
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



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	61.2%	218	356	35.0%	Improvement	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	24.6%	447	1821	35.0%	Normal Variation	Consistently Fail
Sunderland & South Tyneside Place Team	54.1%	278	514	35.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Performance increased to 30.5% in April.

Root Cause of the performance issue

- 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

- Monthly QI steering group is being re-established in Community CBU
- Fortnightly waiting list meetings overseen by each team.
- Variation in the number of referrals is being looked at to understand if this is linked to the recording of Urgent referral recording and accuracy of contact recording or another factor.

Expected impact and by when

It is expected that this metric continues to improve throughout 2024 with the introduction of Dialog.

A11 - % 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)**

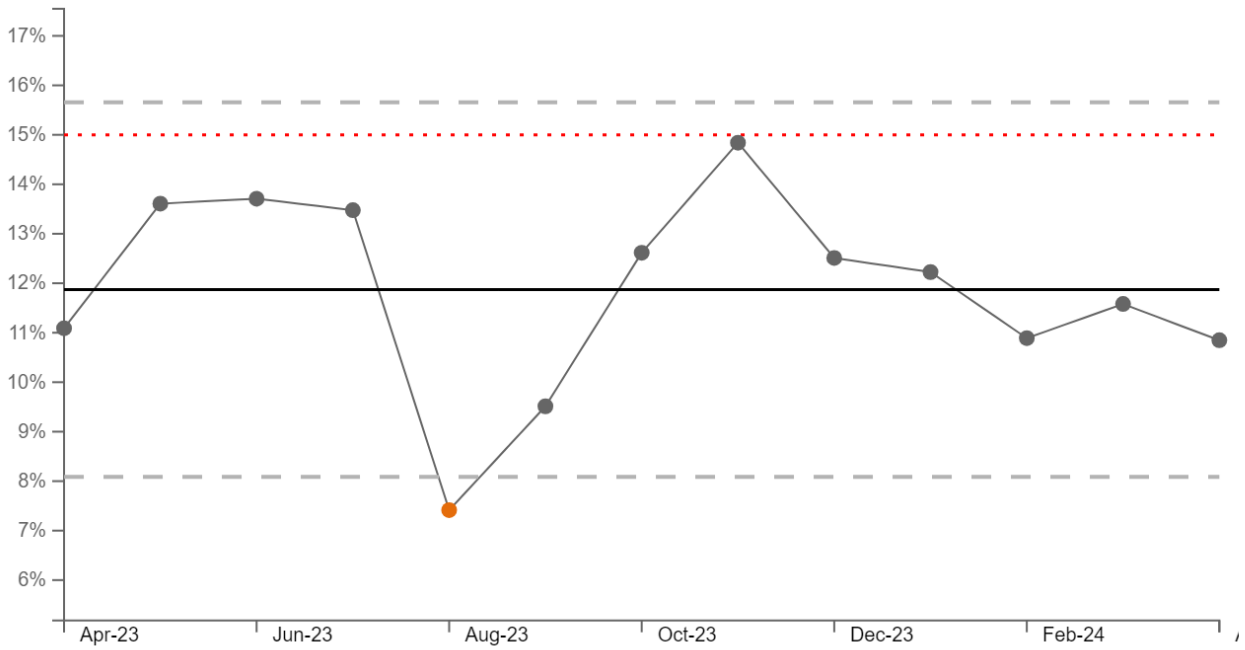
Performance - 10.9%

Standard - 15.0%

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

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

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



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	8.5%	365	4313	15.0%	Normal Variation	Consistently Fail
North Cumbria & Northumberland & North Tyneside Place Team	13.1%	253	1934	15.0%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	88.3%	68	77	15.0%	Improvement	Consistently Achieve

Feedback

What the chart tells us

Performance decreased slightly to 10.9% in April

Root Cause of the performance issue

- Waits are predominantly within the neurodevelopmental pathways with increased demand on the pathway.
- Differences in practice around neuro 'welcome events' across the Trust.

Improvement Actions

- There is a new pathway for neurodevelopmental pathways that has been signed off by the Trust and is being rolled out in a phased approach.
- Further work with NENC system leaders is taking place to discuss how as a system we improve access and experience of CYPS with a neurodevelopmental need.

Expected impact and by when

There is a national focus on neurodevelopmental pathways, which has recognised the amount of demand for diagnosis and how we approach meeting neurodevelopment needs. It is expected that the demand for diagnosis will continue throughout 2024, the expected impacted of actions will be to mitigate the increasing trend of waits during 2024, it is not expected to see a complete reversal due to the continuing demand for neurodevelopmental services.

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

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

Risk Rating - High (Action)

Actual/Forecast - -£2.5m

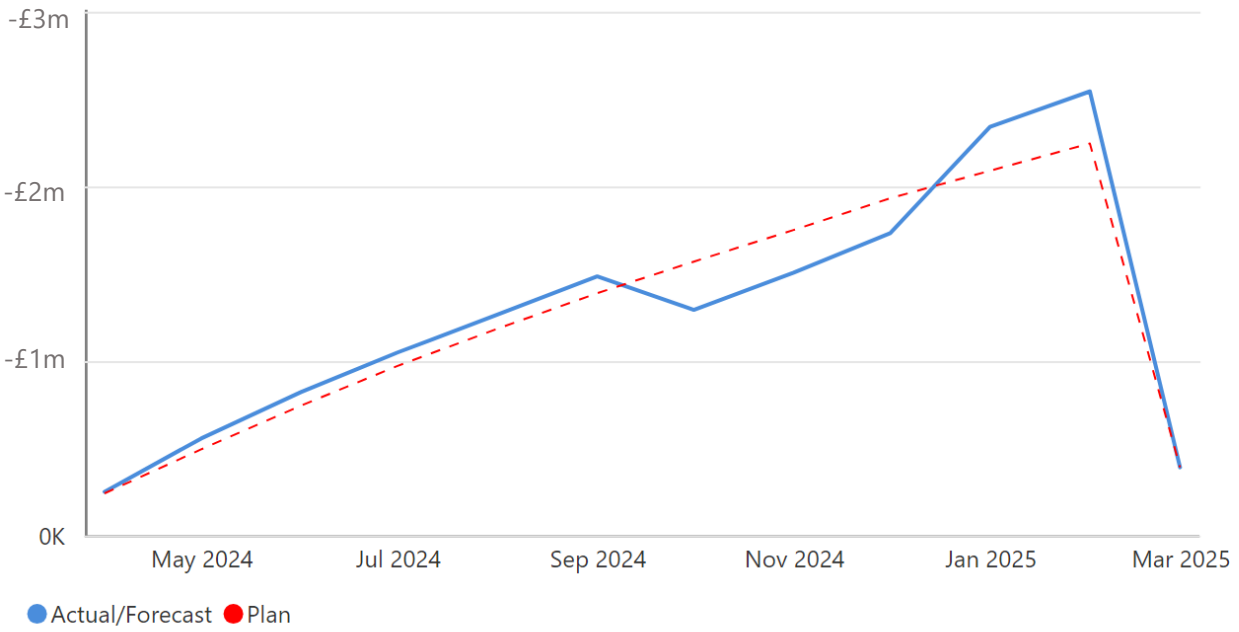
Plan - -£2.5m

Not Applicable

Not Applicable

DQ - No Concern

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	-4,206	-4,015		
Inpatient Care Group	-715	-1,220		
Specialist Care Group	-2,214	-2,179		
Support & Corporate	9,648	9,836		

Feedback

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 efficiency plans.
- BDG monthly finance will focus time on plans for longer term financial sustainability. The Trust will agree trajectories for service to plan to deliver costs in line with the contracted income by 2027.
- 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.
- Ongoing discussions with the ICB re the pressure on the Trust CDEL for 2024/25. Based on the current programme the Trust will breach the allocated limit. The Trust is seeking slippage to increase the CNTW limit for this year.
- Weekly meeting to review and maximise the Trust cash balances.

3. STRATEGIC AMBITION 2 - PERSON LED CARE, WHERE AND WHEN ITS NEEDED

Darren Best, Chair

3.1 INTEGRATED PERFORMANCE REPORT ? PERSON LED CARE, WHEN AND WHERE IT'S NEEDED

Ramona Duguid, Chief Operating Officer

For Assurance

4. STRATEGIC AMBITION 3 - A GREAT PLACE TO WORK

Darren Best, Chair

4.1 PEOPLE COMMITTEE ASSURANCE REPORT

Brendan Hill, Committee Chair

For Assurance

REFERENCES

Only PDFs are attached

4.1 People Committee Assurance Report June 2024.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Wednesday 5 June 2024

Name of Board Committee	**People Committee**
Date of Committee meeting held	1 May 2024
Agenda items/topics considered	See below
Date of next Committee meeting	31 July 2024

1. Key areas of focus:

- Chair's Business
  - Terms of Reference. Minor amendments have been made to the ToR, including the membership of the Committee. These were agreed for future Board approval.
  - Agenda Restructure. The focus topic item will be removed from the agenda going forward. Bi-annual workshop-style sessions will be held to deep dive into key topics.
  - Workshops. Two workshop dates are confirmed as Wednesday 26 June between 11.00am and 2.00pm and Wednesday 27 November from 10.00am until 1.00pm. 'Employee Relations' and 'Workforce Establishments and Transformation' have been arranged for June and November respectively. Two remaining slots have yet to be agreed.
- Workforce Performance Report – **discussion and assurance**
- Guardian of Safe Working Hours Quarterly Report **- assurance**
- Raising Concerns/Whistleblowing Report – **discussion and assurance**
- EDI Action Plan update – **assurance**
- Health and Wellbeing update – **to note**
- Equality, Diversity and Human Rights Annual Report – **discussion**
- Trade Union Facilities Time Report – **discussion and decision**
- Training Requirements Prioritisation and Framework for Managing Delivery – **assurance**
- 2023 Education and Training Self-Assessment Report – **to note**
- Internal Audit Report – Local Onboarding – **discussion**
- Bank Review - **discussion**
- Freedom to Speak up Action Plan Update - **discussion**
- Board Assurance Framework – **discussion and assurance**

2. Current risks and gaps in assurance and barriers to closing the gaps

During the meeting, the Committee highlighted and discussed the following issues in terms of current risks and gaps in assurance.

<u>Clinical supervision</u>
There continues to be a decrease in clinical supervision, (target of 80%, currently 51.9%) and it was noted that this remains an area of focus for the CQC and part of the Trust's CQC Must Do actions. Action: In depth work is taking place looking at the way supervisions are carried out and recorded. A more comprehensive report will be provided once that work has been undertaken. (Update 31 July 2024)

Staffing establishments
The Committee noted the gap in assurance regarding the development of a process to agree staffing establishments. It was also noted that this would form a significant part of the development of the overarching workforce plan. It was noted that despite the priority focus on reducing temporary staffing, having a substantive and clear workforce plan would significantly contribute to the Trust's strategic ambitions in relation to the provision of high quality, safe care, and the financial position. Action: Workforce Plan and establishments to be reviewed in line with changes to the clinical model and forms part of the annual plan priorities. (Update November 2024)

Local Onboarding

Internal Audit report highlighted limited assurance in terms of local onboarding processes. The audit identified a number of gaps in terms of monitoring and assurance. There is a plan in place to rectify this and corporate and local induction has been included in the workforce performance report to ensure it is monitored. (Update July 2024)

Exit Questionnaires

The response rate for exit questionnaires is low (8.4% this quarter which is a significant reduction from the previous quarter). This impacts the understanding of why staff leave the Trust to enable actions to be taken to support retention. The Trust has moved to the ESR Exit Questionnaire from April 2024 which will hopefully improve the response rate in the future.

3. Key challenges now and in the medium term

- The new operational structure went live in April. This will provide an opportunity from a workforce perspective to provide further clarity on pressure points across the organisation in terms of staffing establishments, use of temporary staff, training needs, and staff development.
- Meeting training trajectories remains a challenge. However, completion of the training review will ensure appropriate focus is given to safety critical training courses.
- Clinical activity remains high which causes some challenges in terms of key metrics eg, training completion, appraisals, clinical and management supervision.
- Freedom to Speak Up Guardians (FTSUGs) have highlighted potential challenges with regards to the speaking up culture in the Trust. Analysis / exploration of this to be further discussed during June.

4. Impact of actions taken to date on the achievement of our strategic ambitions

Turnover
Figures have consistently improved for the past seven months.

Health and Wellbeing
The Committee was updated on a range of wellbeing initiatives which have been developed for staff over the previous 6 month period to support SA3 – Great Place to Work. This included a number of actions around financial wellbeing. A successful NHS Charitable Funds bid has funded a Menopause Advisor Helpline via Vivup Employee Assistance Programme from 1 May 2024. This bid has also funded a bereavement support post for six months within the Staff

Psychological Centre (SPC). It was noted that one of the key areas of absence in terms of trends was around bereavement.

Sickness

Provisional sickness figures are the lowest reported for seven months. Continued focus has been given to support staff to stay at work in terms of reasonable adjustments etc. The regional wellbeing hub continues to provide a service to providers across the region in terms of mental health support.

Appraisals

Positive improvement in appraisal rates towards the 85% standard following a targeted approach.

Training Review

Executive Management Team has approved the recommendations from the Task and Finish Group which has been in place for a number of months. Group was set up to

- Review the current training needs analysis for staff groups and settings (eg, current training commitments for registered clinical staff in inpatient/community settings).
- Prioritise training to ensure that the correct focus is put on the most important training courses.
- Recommend a framework for overseeing performance in training trajectories moving forward.

Prior to the review, 27 training courses had a standard against them, however, there were around 50 courses in total so many had no agreed standard in terms of compliance. Only 9 courses routinely met the trajectory. The group reviewed all training and some courses were removed as they were no longer relevant, whilst a couple of new courses were added.

The group identified 49 courses and these were then prioritised between 10 (greatest priority) and 3 (least priority). Based on the prioritisation all courses now have a standard against them.

The framework developed by the group recommended that only those courses of priorities 9 and 10 will be reported via the IPR to Board. All other courses will be monitored at local level through the Well Led Reviews and will be reported to the People Committee.

Review of Staffing Solutions

The Bank Staff review is ongoing, however, the Committee were updated on the work so far. This has included:

- Detailed review of systems, processes and accountability in place for Staffing Solutions.
- Communications for the bulletin and presentation at the managers meeting to help ward managers understand how to process staff for the bank. Further work will be done in relation to onboarding substantive staff.
- Exploration of ‘customer feedback’ following process map approach.
- Review of rates of pay and incentives.
- Draw down options – wage stream.
- Robust supervision plan.
- Website development.
- Development of a flexi pool.

- More responsive advert for bank only Bands 3 and 5. A shared responsibility between Staffing Solutions and operational group colleagues in short listing and interviewing of candidates.
- Embedded process for reviewing inactive workers and expectations of shifts worked.

The actions so far have seen progress in terms of recruiting to Bank posts and increasing use of Bank staff across teams.

5. Barriers to progress and impact on achievement of strategic ambitions

The key barrier to progress of strategic ambitions is the absence of an overarching workforce plan. A number of actions have been developed and will be progressed over the coming months. This will be further discussed at the People Committee Workshop in November.

6. Actions to be taken prior to next meeting of the Committee

Further analysis of concerns raised via the Freedom to Speak up Guardians where possible. Exploration of the reasons why staff may not wish to raise concerns. Culture of raising concerns to be discussed at Trust Leadership Forum and with Executive Directors during June to ensure a collective approach is taken.

7. Items recommended for escalation to the Board at a future meeting

Two key items will be discussed at Trust Board in June:

Raising Concerns/Whistleblowing Report.
The Equality, Diversity and Human Rights Annual Report.

The detail of which is included in separate papers.

In terms of further escalation, the Committee feels it has an appropriate level of assurance in terms of the risks on the Board Assurance Framework, and Committee reporting.

8. Summary of Approval, decisions and ratification of items taken the meeting

- The Trade Union Facilities Report was approved for publication in line with the Public Sector requirements.

9. Review of Board Assurance Framework and amendments thereon

At the May meeting of the People Committee, BAF risks associated with the delegated responsibility of the Committee were reviewed. The highest scoring BAF risk (scoring 16 and above) is as follows.

Risk	Score	Current gaps in assurance
254 – Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	4(L)X4(I) 16	• Absence of a sustainable workforce plan. • Establishment control to be reviewed to ensure accurate recording and reporting of vacancies. • Current workforce skills are not currently recorded and mapped against post requirements. • Skills gaps are not identified, and adequate training put in place to address the shortfalls. • Inclusive recruitment work has had an impact on increasing the BAME workforce but predominantly this is in lower banded posts. • Strengthening of internal process for accessing development monies required. • Release of staff to undertake relevant training and development opportunities is currently a challenge. • Lack of joined up approach between appraisals and training requirements. • Challenges ensuring the temporary workforce maintain the required skills. • More robust recording and reporting mechanisms is required to enable leadership and management development and succession planning.

There were no changes recommended to the BAF risks aligned to the work of the People Committee.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.

Brendan Hill
People Committee Chair
May 2024

Lynne Shaw
Executive Director of Workforce and OD

4.2 SAFER STAFFING REPORT (EXCEPTION REPORT)

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

For Assurance

REFERENCES

Only PDFs are attached

4.2a Safer staffing report Board June 2024.pdf

4.2b Appendix 1 Safer Staffing Report Board June 2024 (March information).pdf

Name of meeting	**Board of Directors Board meeting**
Date of Meeting	**Wednesday 5th June 2024**
Title of report	**Safer Staffing Report**
Executive Lead	**Sarah Rushbrooke, Executive Director Nursing, Therapies and Quality Assurance**
Report author	**Liz Hanley, Associate Director Nursing and Quality**

Purpose of the report	
To note	✓
For assurance	✓
For discussion	
For decision	

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

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

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

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Working together with service users and carers we will provide excellent care. Supporting people on their personal journey to wellbeing. There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands (SA1.4).

SA4 The Trust's mental health and disability services will be sustainable and deliver real value to the people who use them.

A failure to develop flexible robust Community mental health services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm (SA4).

Report to the Board of Directors Board meeting.
Wednesday 5th June 2024
(March 2024 data)

Safer Staffing Report

Executive Summary

The purpose of the report is to provide assurance on the position across all in-patient wards within CNTW, in accordance with the National Quality Board (NQB) Safer Staffing Requirements. Trusts must formally ensure that the National Quality Board's 2016 guidance is embedded in their safe staffing governance, ensuring that the following three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes.

There is also a requirement to provide Care Hours Per Patient Day (CHPPD) planned and actual for registered and unregistered nursing via Unify monthly. The narrative in the report reflects the staffing position for March 2024 and a summary of CHPPD fill rate information for this time period is incorporated into Appendix 1, at page 11.

Safer Staffing issues to note.

The following safer staffing issues are of note:

- Overall, the nursing workforce is considered inexperienced, with a high proportion of preceptees and Internationally Educated Nurses who are unable to take charge of the ward. In addition, following completion of preceptorship, several band 5 nurses are being successfully appointed to band 6 roles in the community, which is resulting in retention issues for inpatient wards.
- Coexisting conditions and complex physical health needs increase patient dependency, acuity of need, monitoring requirements and the need for patients to be escorted away from CNTW sites to undergo diagnostic screening or testing and/or to receive treatment.
- Staffing pressures at Walkergate Park Hospital result from a high level of physical health needs and related care, treatment and interventions.
- Standalone units have been identified as being at increased risk of the effects of staffing pressures, including Yewdale ward; Elm House; Rose Lodge; Lotus ward and the Mitford unit.
- There is a significant vacancy rate in secure services and an increased incidence of violence and aggression.
- Positive feedback has been received relating to the improved environment of Children and Young People's Services (CYPS) and there is increased support available from the wider CYPS services, following consolidation of services on the Ferndene site.

Work is in progress to enhance the accessibility of the CHPPD data by including contextual information, including turnover, vacancy, sickness and temporary staffing usage information.

The Mental Health Optimal Staffing Tool exercise is currently in progress and the outcome will be reported in July 2024.

Risks and mitigations associated with the report

Risks and mitigations are summarised in the narrative pages of the attached safer staffing report.

Recommendation/summary

It is recommended that the Board accepts this report.

Name of author

Liz Hanley
Associate Director Nursing and Quality

Executive Lead

Sarah Rushbrooke
Executive Director Nursing, Therapies and Quality Assurance

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Safer Staffing Report

2023-24 Month 12 (March 2024)

With YOU in mind

Safer Staffing Report - Trust-wide Headline Commentary

Headline Challenges

Issues impacting on safe staffing:

- A high proportion of preceptees and Internationally Educated Nurses who are unable to take charge of the ward.
- A significant vacancy rate in Secure Services.
- An increase in the number of patients requiring an enhanced level of observation.
- A high level of patient acuity, compounded by co-existing conditions and physical health needs.
- An increase in the number of patients who are Clinically Ready for Discharge (CRFD) with no identified arrangements for ongoing care and support.
- Out of pathway patients.

Key focus areas of concern

- Staff members are redeployed across CBUs according to need, which can reduce continuity of care and job satisfaction.
- Pressures relating to enabling staff training.
- Overall, the registered nursing workforce is relatively inexperienced.
- There is a high level of incidents involving violence and aggression; focused work is in progress with respect to Mitford and Hadrian 1.
- There are specific risks associated with stand-alone units (Yewdale; Elm House; Rose Lodge; Lotus ward; Mitford unit) and hospital sites not easily accessible by public transport (Northgate; Ferndene).
- There is increasing incidence and complexity of physical health needs, with specific reference to the wards at Walkergate Park.

Positive Assurance / Improvement

- Staff turnover is decreasing (Central Locality).
- Work is in progress to increase the capacity of the nurse bank to address temporary staffing needs, rather than using agency workers; a recurring advert for band 3 bank workers is in progress.
- There is focused work is being undertaken to promote staff wellbeing.
- Implementation of the Quality Improvement Framework.
- Progress of Inpatient Staffing Enhanced Multidisciplinary Team and Evidence-based Safer Staffing Tools (e.g. Mental Health Optimal Staffing Tool) workstreams.
- Positive and Safe cohort meetings.

Mitigations/actions

- Daily level-loading of experienced registered nurses is undertaken.
- Daily or twice daily staffing huddles are held to reassess safe staffing levels.
- Implementation of evaluation of competence at 9 months in the preceptorship process.
- Staff wellbeing meetings are held, and relevant actions implemented.
- A robust authorisation process is in place for temporary staff utilisation.
- Engagement in the Vacancy Control Process to provide evidence of need to recruit to clinical vacancies.
- Use of Occupational Health to support staff returning to work.

Safer Staffing Report - Adult Acute Headline Commentary

Headline Challenges

- High numbers of preceptee and internationally educated nurses who cannot take charge (adding pressure to those who can).
- High levels of acuity requiring enhanced engagement and observations to manage patient acuity and risk.
- Patients who are clinically ready for discharge with no identified arrangements for ongoing care and support.
- Use of temporary workforce to support vacancies, enhanced engagement, sickness and other absences.
- Issues releasing Adult Nurses to support the development of the physical health hub, reducing available staff to roster on shift.
- Physical Health complexities.
- On some wards, the Ward Managers have worked into the staffing numbers frequently to provide additional registered nurse support.
- Discussions are taking place relating to the recent environmental issues raised on Bede and whether the ward needs to close.
- Yewdale is an isolated unit (80 mins approximate travel time from the nearest CNTW site). There are ongoing staffing deficits resulting in a continued need for agency usage, particularly on Yewdale; due to the ward location, it is also difficult to staff with bank or agency and requires frequently having to pay

Key focus areas of concern

- There is an ongoing need to redeploy staff members to wards other than their base ward, reducing continuity of care.
- Pressure relating to meeting clinical needs.
- Workforce remains relatively inexperienced overall.
- Daily difficulties level-loading of substantive post-preceptorship Band 5 nurses on the wards.
- Essential staff training is not being achieved: difficulties releasing staff members due to staffing pressures.
- Levels of incidents relating to violence and aggression impact on staff wellbeing: for example, 33 incidents of Violence and aggression on Hadrian 1, with 21 involving one patient.
- Requirements to utilise seclusion to manage risk behaviours: for example, on 5 episodes of seclusions related to the same individual (North Cumbria).
- Use of temporary workforce continues.
- Following completion of preceptorship, B5 Preceptees are progressing quickly to Band 6 posts, out with inpatient CBU.
- Increase in levels of acuity on Hadrian1 and Yewdale.
- High incidents of sickness absence, both Long Term Sickness and Short-Term.

Positive Assurance / Improvement

- Staff turnover appears to be reducing, retention remains the biggest challenge.
- Preceptorship rotation is planned to help ease redeployment concerns.
- Use of temporary workforce: Bank being used rather than agency evidenced by data.
- Focused work on staff wellbeing is in progress.
- Physical Health Champions have been realigned on the wards.

Mitigations/actions

- CBUs use locally agreed staffing huddles to manage resource gaps, with senior overview to support pressures.
- Staff wellbeing meetings are held.
- Use of temporary staffing is only when all other options have been explored or related to KPI training requirements.
- Authorisation process for temporary workforce.
- Ongoing recruitment for all Band 3 vacancies.
- Use of Occupational Health to support staff returning to work.
- The Physical Health offer is being reviewed, in line with the Physical Health Strategy
- Clinical Nurse Manager and additional senior nursing support are aligned to Yewdale daily.
- There is as Local agreement between senior teams on Yewdale and Evidence Based Medicine for admissions to be screened directly prior to admission. No admissions are accepted after 3pm.
- The 136 suite on Yewdale temporarily closed.
- Currently recruiting staff for flexi-pool opportunities in North Cumbria to reduce the use of bank and agency.

Safer Staffing Report - PICU Headline Commentary

Headline Challenges

- There is a lack of substantive experienced post-preceptorship Band 5 staff.
- High admission rate.
- High acuity: patients often have a forensic need/risk; this can be compounded by co-existing conditions, such as autism, and substance misuse.
- Use of restrictive practice to support clinical need and safety (Seclusion).
- Out of pathway patients.
- Patients who are clinically ready for discharge, with no identified arrangements for ongoing care and support.
- Enhanced Engagement and Observation levels.
- Essential staff training not being achieved as not able to release staff members.
- Use of temporary workforce to support vacancies, due to enhanced engagement, sickness and other absences.
- Complex Physical Health needs.
- Vacancies within the Ward Leadership Team.
- Mixed gender PICU/Ward creates risks relating to sexual safety.

Key focus areas of concern

- Daily difficulties level-loading of substantive post-preceptorship Band 5 nurses on the wards.
- Essential staff training not being achieved.
- Use of temporary workforce.
- Levels of incidents relating to violence and aggression, including the impact on staff wellbeing.
- Band 5 preceptees following completion of preceptorship progress to Band 6 posts out with inpatient CBU.
- Working to achieve parity of esteem (physical and mental health).
- Mixed gender PICU/Ward creates risks relating to sexual safety.

Positive Assurance / Improvement

- Use of temporary workers: Bank worker numbers are increasing reducing the need for agency.
- Focused work on staff wellbeing is in progress.
- HOPE(S) team support to clinical teams is in place.
- Realigned Physical Health Champions.

Mitigations/actions

- Daily staffing hub with senior overview to support pressures.
- Authorisation process for temporary workforce.
- Ongoing recruitment for all Band 3 vacancies.
- Use of Occupational Health to support staff returning to work.
- The Physical Health offer is being reviewed, in line with the Physical Health Strategy.
- Engagement with sexual safety work.

Safer Staffing Report - Adult Rehab Headline Commentary

Headline Challenges

- High numbers of preceptee and internationally educated nurses who cannot take charge (adding pressure to those who can).
- Patients who are clinically ready for discharge with no identified arrangements for ongoing care and support.
- Use of temporary workforce to support vacancies, enhanced engagement, sickness and other absences.
- All wards report a high number of patients who require enhanced engagement and observation. This can also relate to patients who have physical health and frailty need.
- Elm House, Willow View and Bridgewell have several patients with dysphagia, which is a significant risk and requires additional one to one support at mealtimes.
- Higher staff sickness levels at Elm House.
- Patients who are clinically ready for discharge with no identified arrangements for ongoing care and support.
- The continued use of agency staff who are often unfamiliar with patients, to support vacancies, enhanced engagement and observations, sickness and other staffing issues.
- Essential staff training is not being achieved as it is not possible to release staff, due to patient acuity and staffing levels.
- Due to physical health needs, patients received care within the acute Trust, which results in staff support to attend appointments.

Outbreaks:

- Significant Norovirus outbreak on Ruskin, impacting on safer staffing levels, which impacted on Oakwood, as the ward providing additional staffing resource.
- Covid outbreak on Willow View.

Key focus areas of concern

- There is still a need to redeploy staff to wards which is not their base ward, reducing continuity of care.
- Pressures relating to meeting training needs.
- Daily difficulties level-loading of substantive post-preceptorship Band 5 nurses on the wards.
- Barriers to onward care pathways due to unable to identify appropriate care and support.
- Use of temporary workforce.
- The impact of incidents relating to violence and aggression and the impact on staff wellbeing.
- Pressures due to escorting patients to other hospital sites and services.
- High incidents of sickness absence both long-term and short-term.

Positive Assurance / Improvement

- Use of temporary workforce: Bank being used rather than Agency.
- Using the wider Multi- Disciplinary Team to support patient care.
- Focused work on staff wellbeing is in progress.
- Physical Health Champions have been realigned on all wards in South locality.
- Bridgewelll ward pilot of use of choking rescue device (LifeVcac).
- Elm House and Willow View: staff turnover appears to be reducing.
- Ruskin has been able to support preceptee nurses to complete their preceptorship.; Reduction in violence and aggression incidents on Ruskin and Oakwood wards.

Mitigations/actions

- CBUs use locally agreed staffing huddles to manage resource gaps, with senior overview to support pressures.
- Staff wellbeing meetings are being held.
- Use of temporary staffing is only when all other options have been explored. There is an authorisation process for the use of temporary workforce. South Inpatient had and external advert out for all Band 3 vacancies.
- Review Physical Health offer has been strengthened in line with Trust Physical Health Strategy.
- Engagement with sexual safety work.
- Currently recruiting staff for flexi- pool opportunities in Cumbria locality to reduce the use of bank and agency workers.

Safer Staffing Report - Older Persons Headline Commentary

Headline Challenges

- High numbers of preceptee and internationally educated nurses who cannot take charge (adding pressure to those who can).
- High levels of acuity requiring enhanced engagement and observations to manage patient acuity and risk.
- Patients who are clinically ready for discharge with no identified arrangements for ongoing care and support.
- Use of temporary workforce to support vacancies, enhanced engagement, sickness and other absences.
- Essential staff training is not being achieved as it is not possible to release staff, due to patient acuity and staffing levels.

Key focus areas of concern

- There is an ongoing need to redeploy staff members to wards other than their base ward, reducing continuity of care.
- Daily difficulties level-loading of substantive post-preceptorship Band 5 nurses on the wards.
- Essential staff training is not being achieved: difficulties releasing staff members due to staffing pressures.
- Continue need to use temporary staff.
- The impact of incidents relating to violence and aggression, including on staff wellbeing.
- Barriers to onward care pathways due to no identified arrangements for ongoing care and support.

Positive Assurance / Improvement

- Staff turnover in Central locality appears to be reducing.
- In Central locality it is planned to rotate preceptees to help ease redeployment concerns from staff.
- Bank being used rather than Agency.
- Using the wider Multi-Disciplinary Team to support patient care.
- Focused work on staff wellbeing is in progress.

Mitigations/actions

- Localities use locally agreed staffing huddles to manage resource gaps, with senior overview to support pressures.
- Staff wellbeing meetings are being held.
- Use of temporary staffing is only when all other options have been explored. There is an authorisation process for the use of temporary workforce.
- Ongoing recruitment to Band 3 vacancies.
- Review Physical Health offer has been strengthened in line with Trust Physical Health Strategy.
- Engagement in sexual safety work.

Safer Staffing Report - CYPS Headline Commentary

Headline Challenges

- Patients who are clinically ready for discharge, with no identified arrangements for ongoing care and support.
- Over 18 years old patients within children's service and difficulty transferring to adult services (out of Trust) also contributes to enhanced engagement and observations, due to safeguarding concerns.
- High clinical acuity within inpatient services.
- Qualified nurse sickness (2 x B6 and 1 x B5 long-term.
- Staffing deficit due to medium-term absence, relating to maternity leave and vacancies.
- Patients have been nursed in acute hospitals requiring high levels of staff resources.

Key focus areas of concern

- Due to redeployment of staff, several new staff members have been employed. These staff members will start at approximately the same time, requiring induction support.
- Increase in enhanced engagement and observations due to the high acuity of need.
- Lotus Ward is a standalone unit, which has a limited response team.
- High use of agency workers due to staff sickness and the acuity needs of the young people.

Positive Assurance / Improvement

- There have been several successful recruitment campaigns.
- Since moving to Ferndene, the environment has been much more positive for the young people and staff (positive feedback has been received).
- Additional support is available from the wider Children and Young Peoples Services workforce due to the location of inpatient services on one site.
- Daily staff wellbeing drop-in sessions with ward manager are in progress.

Mitigations/actions

- Daily staffing huddles are held to review staffing levels with Ward Managers and Clinical Managers.
- Reduction in enhanced engagement and observation levels.
- Staff members are being redeployed from other wards, ensuring supportive skill-mix across the site.
- Drop-in sessions for staff with senior management are in place.
- Reflective practice available for all staff members.
- If agency use cover is required, familiar workers will pick up shifts, which supports continuity.
- Level-loading of skill mix within services, including temporary redeployment of staff to support.
- Current vacancies are out to advert.

Safer Staffing Report - Secure Services Headline Commentary

Headline Challenges

Issues Impacting on Safer Staffing:

- Vacancies: Band 5 x 12.5wte.
- Increased sickness absence 5.81% (13 short-term sickness; 15 long term sickness)
- Increased numbers of preceptees on the wards who require additional support and cannot take charge.
- There is a significant number of patients requiring enhanced engagement and observations due to high acuity of needs.
- Seclusion was used for 13 episodes for 8 patients in March.
- Long Term Segregation continues for some patients.
- Individualised Care Package for a patient required 6 nursing staff to be with them continually.

Key focus areas of concern

There has been a noted increase in incidents of violence and aggression. High level activity data:

- 20 incidents on Elsdon x 1 patient
- 18 incidents on Alwinton x 2 patients (10, 8)
- 14 incidents on Harthope x 2 patients (9, 5)
- 9 incidents on Tweed Low Secure x 1 patient
- 7 incidents on Tyne Low Secure x 1 patient

Positive Assurance / Improvement

- Staff drop-ins increasing senior leadership accessibility.
- Staff and Patient Debriefs held following violence and aggression incidents.
- Continued monitoring of agency use with reduction to 18 WTE (additional 9 WTE for Individualised Care Package).

Mitigations/actions

- Daily Staffing Huddles to level-load experience and agency and any gender specific observations.
- Recruitment is ongoing.
- Nursing Assistants Inductions/Development are in progress.
- Weekly continued professional development programme is being supported on the wards.

Safer Staffing Report - Learning Disability & Autism Headline Commentary

Headline Challenges

- High numbers of preceptee and internationally educated nurses who cannot take charge (adding pressure to those who can).
- High levels of acuity requiring enhanced engagement and observations to manage patient acuity and risk.
- Patients who are clinically ready for discharge with no identified arrangements for ongoing care and support.
- Essential staff training is not being achieved: difficulties releasing staff members due to staffing pressures.
- Use of temporary workforce to support vacancies, enhanced engagement, sickness and other absences.
- Increase in Hate Crime on Rose Lodge, which is impacting on staff.
- Use of temporary workforce to support vacancies, enhanced engagement, sickness and other absences.
- Rose Lodge is limited to an internal response team, due to being standalone unit
- Edenwood: one of the patient always requires 3 staff with them; additional site support is available if needed.
- Ongoing unfilled vacancies on Mitford.

Key focus areas of concern

- Daily difficulties level-loading of substantive post-preceptorship Band 5 nurses on the wards.
- Essential staff training not being achieved.
- Use of temporary workforce.
- Levels of incidents relating to violence, aggression and assaults on staff and how this impacts on staff wellbeing.
- Patients who are clinically ready for discharge with no identified arrangements for ongoing care and support.
- Focused work on Mitford in relation to RIDDOR incident.
- Focused workforce work in relation to right to Work on Mitford.

Positive Assurance / Improvement

- Use of temporary workforce: Bank being used rather than Agency.
- Focused work on staff wellbeing is in progress across all wards.
- Work on Rose Lodge with the National HOPE(S) team is in progress to support discharge of a patient now clinically ready for discharge.
- Physical Health Champions have been realigned on Rose Lodge.
- There were no incidents recorded relating to violence and aggression on Edenwood.

Mitigations/actions

- Daily level-loading of experienced registered nurses is undertaken on Mitford.
- Daily staffing hub with senior overview to support pressures on Rose Lodge; twice daily on Mitford and Edenwood to reassess safe staffing levels.
- Weekly staff-side drop-in support to promote staff wellbeing on Rose Lodge.
- Staff wellbeing meetings for Mitford staff are held and relevant actions progressed.
- A robust authorisation process is in place for temporary workforce engagement.
- Rose Lodge staff and senior managers are working with the police to pursue individual incidents in relation to Hate Crime.

Safer Staffing Report - Neuro & Specialist Headline Commentary

Headline Challenges

- High levels of sickness, over the Trust target of 5%, however 3 wards within target (Beadnell, 31a, and Gibside)
  - Ward 1: 12.4% increase
  - Ward 2: 11.34% decrease
  - Ward 3: 9.20% increase
  - Ward 4: 7.38% decrease
- Increased acuity on several wards across the CBU.
- Acuity associated with complexities of physical health needs, rather than mental health needs, at Wakergate Park. This often means 2 staff members are required for interventions such as moving and handling, personal care and Percutaneous Endoscopic Gastrostomy (PEG Feeding tube) care.
- High numbers of preceptee and internationally educated nurses who cannot take charge (adding pressure to those who can).

Key focus areas of concern

- Complex discharge requiring ward support for twice daily interventions putting additional pressure on 31a ward staff.
- Frequent Prevention and Management of Violence and Aggression (PMVA planned intervention) required to administer Nasogastric (NG) feed to patient on ward 31a.
- Complex admission on Ward 4, which has required increased nursing and operational management intervention to support the family.

Positive Assurance / Improvement

- 2 Nursery Nurses starting in April on Beadnell.
- 3 Specialist wards within sickness target and some other wards showing a decrease in sickness (Wards 2 and 4).
- Lower numbers of vacancies in comparison to other parts of Trust.
- Lower frequency of violence and aggression in comparison to other parts of Trust.
- Work is ongoing to reduce sickness levels and support people back to work with reasonable adjustments where required.

Mitigations/actions

- CBU staffing huddle is held twice per week to review clinical activity/sickness and level-load staffing resources where possible.
- Acuity of admissions considered weekly to ensure patient safety for planned admissions.
- Appropriate escalation to Clinical Manager/Point of Contact (POC) to support staffing levels as and when needed.
- Regular liaison with Workforce to support long-term sickness cases and proactive approach to sickness management.
- Proactive recruitment: vacancies are advertised promptly following weekly vacancy control meetings.
- Band 3 recruitment at Walkergate Park Hospital now shortlisted.
- Acuity: regular reviews by the Multi-Disciplinary Team and Associate Director oversight where required to support discharge planning.
- Proactive management of disciplinary cases to minimise impact on clinical services whilst maintaining safety.

Q11 - Staffing fill rates

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

Risk Rating - **High (Action)**

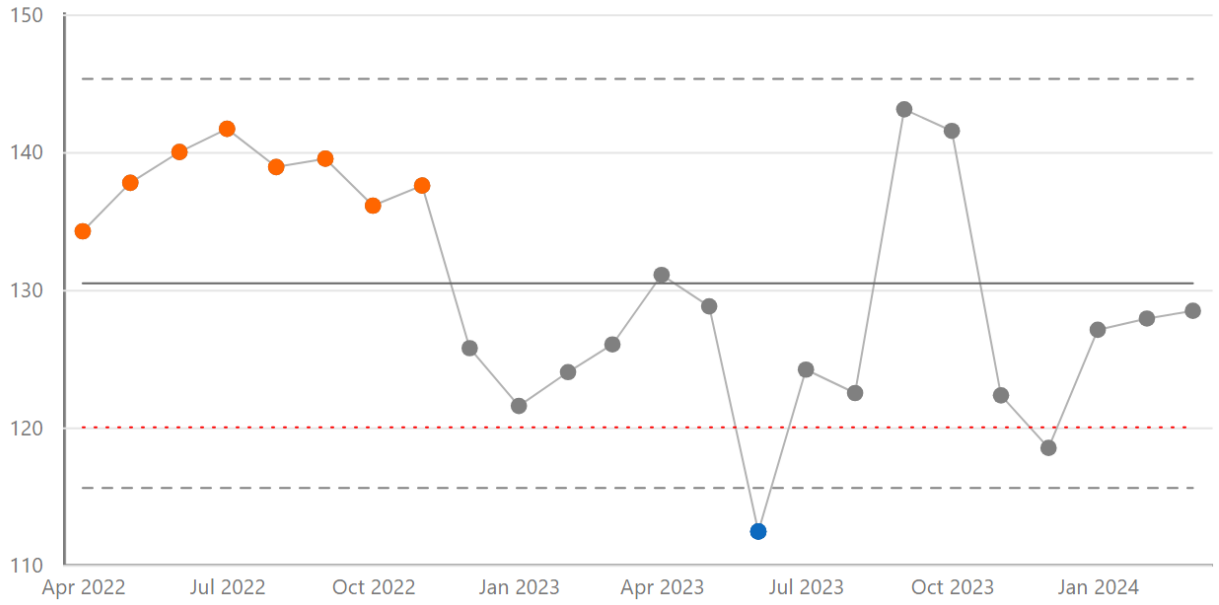
Performance - 128.5%

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	135.3%	120.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	143.7%	120.0%	Normal Variation	Achieve at Random
North Locality Care Group	134.8%	120.0%	Normal Variation	Achieve at Random
South Locality Care Group	110.4%	120.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Staffing fill rates were reported at 128.5% in March 2024 which is an increase from 127.9% in February.

Root Cause of the performance issue

- There remain vacancies across inpatient services.
- Localities continue to struggle achieve staffing fill rate of less than 120% affecting the overall performance of this measure.

Improvement Actions

- Recruitment activities continue.
- Rollout of new shift allocation software planned for Q4 across wards.
- Reviews of all agency usage.
- Improvement Review of temporary staffing processes
- 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.

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.

4.3 EQUALITY, DIVERSITY AND INCLUSION REPORT

Lynne Shaw, Executive Director of Workforce and OD

For Assurance

REFERENCES

Only PDFs are attached

4.3 Equality Diversity and Human Rights Annual Report 2023-24 FINAL.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 5 June 2024**
Title of report	**Equality, Diversity & Human Rights Annual Report 2023-24**
Executive Lead	**Lynne Shaw, Executive Director of Workforce & OD**
Report author	**Chris Rowlands, Equality, Diversity & Inclusion Lead** **Emma Silver Price, Equality, Diversity & Inclusion Officer**

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	x
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 Committee		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 Committee	x		
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		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA3 – A Great Place to Work Risk of poor staff motivation, engagement and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Board of Directors
Wednesday 5 June 2024

Equality, Diversity & Human Rights Annual Report 2023-24

1. Executive Summary

This report is produced in line with our statutory requirements under the Equality Act 2010 to report on work that has taken place and to outline Equality Objectives for the coming year(s). Once received and approved its publication will meet the Specific Duties of the Equality Act 2010 to publish:

- equality objectives, at least every four years
- information to demonstrate their compliance with the public sector equality duty

2. Key issues, significant risks and mitigations

No issues to note.

3. Recommendations/summary

The Board of Directors is asked to note the report.

Christopher Rowlands
Equality, Diversity & Inclusion Lead

Lynne Shaw
Executive Director of Workforce & OD

Emma Silver Price
Equality, Diversity & Inclusion Officer

16 April 2024

Introduction

This report highlights the work undertaken by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust during the past year to make the NHS a better and fairer place for patients and staff. The report covers the period from April 2023 to the end of March 2024. It also details our equality objectives which were agreed during the year to meet our requirements under the Equality Act of 2010.

It is named ‘Equality, Diversity and Human Rights’ report because it shows the work we have done to:

- Help all people, whoever they are, to receive high quality health care – we call this equality.
- Recognise and celebrate the fact that every person is an individual – we call this diversity.
- Make sure every person is treated with dignity and respect – we call this human rights.

Key highlights for the Equality Diversity and Inclusion Team this year have been working closely with our locality groups and staff networks particularly around cultural awareness and we hope that we can continue this work with the new Care Groups during 2024-2025. The coming year for EDI in the Trust will see an important focus on health inequalities and we will be working with the communities which we serve to best meet those needs.
We hope you enjoy reading about our achievements in the past year, and we look forward to telling you about our busy year ahead.

Staff Networks

The Trust has three Staff Networks: Cultural Diversity Staff Network, Disabled Staff Network, and LGBTQ+ Staff Network. Each network has two co-chairs who meet regularly with the Equality, Diversity & Inclusion Team to talk about cross-cutting issues as well attend Trust Leadership Forums. Each staff network is allocated an annual budget for initiatives that will support key work to address Trust-wide actions, as well as weekly protected release time for each co-chair to undertake network duties.

As well as Staff Networks, there are a number of support groups that all staff are welcome to attend. These include:

- CNTW Armed Forces and Veterans Association
- The Mind, Health & Wellbeing Community
- Staff Carer Support Group
- Menopause cafés
- AUsome cafés
- Prayer cafés

The following sections provide highlights of staff network activities during 2023-24:

Cultural Diversity Staff Network:

The Cultural Diversity Staff Network actively engages and contributes ensuring equality, acceptance and inclusion within the Trust.

Black History Month Event

The theme for 2023 was “saluting our sisters”, focusing on the contributions of black women to our country. This hybrid event took place on 6th October 2023 and was open to all staff and volunteers. The following prestigious guests attended:

- Reni Eddo-Lodge, award-winning journalist and author of #1 Sunday Times bestseller ‘Why I’m No Longer Talking to White People About Race’. (Her book was available to staff via CNTW library services, and the Library hosted lunchtime book clubs for staff to discuss the book.)
- Paul Attwal, founder of the See Me First initiative, which was launched across CNTW as part of the event.
- Paul Deemer, Head of Diversity and Inclusion at NHS Employers.

Continuing the theme, the Network also hosted a special guest speaker event with Dr Lade Smith CBE, President of the Royal College of Psychiatrists (RCPsych), on 20th October 2023.

See Me First Initiative

Aligning with Black History Month, the Cultural Diversity Staff Network in conjunction with the Trust, launched the See Me First Initiative which encourages pledges for active allyship. The executive board made a statement of support for the initiative that said “The Trust is an open, non-judgemental, and inclusive organisation that will not tolerate racism or discrimination. We celebrate the diversity of our staff and community. We will treat all our staff equitably, with dignity and respect, whatever their race, gender, religion, age, disability or sexual orientation.”

Since the launch, 252 staff have taken their pledge to actively take responsibility for their allyship. The pledge form asks staff to write what has motivated them to take the pledge, here are just a few of the quotes from those who have pledged:

- “I want discrimination to stop in the workplace and everyone to be treated as one, irrespective of their skin colour.”
- “I work with a lot of agency staff, I want to be a champion against racism and discrimination.”
- “To be inclusive in all walks of life.”
- “I believe that people should be treated fairly, not by their skin, gender or identities but rather they should be acknowledged for their accolades. See me for the skills I have to do my job.”

Disabled Staff Network:

Committed to creating a fair and diverse workplace. The staff network actively engages and contributes towards ensuring equality, acceptance and inclusion within the Trust.

Disability History Month

As part of Disability History Month in 2023, the Disabled Staff Network arranged a series of ongoing 'lunch and learn' sessions across many months. These sessions are available to all staff and have been extremely well attended, they included:

- Keiran Rose: The Autistic Advocate.
- Martin Pistorius: How my mind came back to life, and no one knew.
- Yasmin Sheikh: Disability Rights UK & Reasonable Adjustments.
- Elaine McGreevy: Ableism is Everyone's Business.
- British Dyslexia Association: Dyslexia Training.
- Kerry Pace: Chronic Conditions, Pain and Fatigue in the Workplace.

LGBTQ+ Staff Network:

The aim of the LGBTQ+ Staff Network is to promote a working environment where all LGBTQ+ staff feel supported, valued, and to challenge discrimination.

LGBTQ+ History Month Conference

The theme for LGBT+ History Month 2024 celebrated LGBT+ peoples' contribution to the field of medicine and healthcare, both historically and today. The LGBTQ+ Staff Network hosted four lunchtime sessions for staff throughout February 2024, these focused on:

- Stories from our own staff and their time in the NHS.
- Gender: the past, the present and the future.
- LGBT+ over the years: a discussion around LGBT+ in older person services.
- Neurodiversity and LGBT+.

Cultural Celebration Events

In February 2023, CNTW's Equality, Diversity and Inclusion (EDI) Team were approached by a Nursing Assistant on Rose Lodge (specialist learning disability treatment and assessment unit), who was interested in getting involved with EDI work ongoing in the Trust. Conversations started to focus specifically on the need to explore piloting Cultural Celebration events within the Trust, with the aim to celebrate the Trust's increasingly diverse workforce and to offer opportunities to learn about and share cultural cuisine, attire, music, and much more.

Following multiple discussions, the Trust agreed that the first Cultural Celebration Event should take place after Ramadan, Easter and Pesach, and to take place on a weekend or Bank Holiday in the hope that more staff would be able to participate. Further input was gathered from ward managers, a Consultant Liaison Psychiatrist (with particular knowledge in

cultural competency, refugees and asylum seekers), and Co-Chair of the Cultural Diversity Staff Network.

CNTW's first Cultural Celebration Event took place on 22 April 2023, it was such a success that a further 5 events took place across different wards within the Trust, with multiple others being planned for 2024.

The six events that took place between April and November 2023 included food originating from many different countries, staff world maps, cultural decorations, country flags, and music with playlists of diverse music compiled by staff. Some of the events had raffles that raised money for CNTW's in-house charity 'The Shine Fund', and attendees of the events were encouraged to add their country flag to the world maps. The world maps started lovely visuals of the diverse workforce of CNTW and many conversations were sparked around cultural attire, food provided, and everyone who participated were completely open and willing to try new cuisines. More fun activities included cultural pop quizzes, and even Indian dance lessons.

Due to the success of these events, CNTW's EDI Officer wrote a 'create your own cultural celebration day' toolkit and published it on the staff intranet for staff to access as and when required. The toolkit covers necessary guidance for teams to get creative and host their own event, it follows five simple steps to get started which includes recommendations for teams such as risk assessments, involving patients, promoting the events, preparing for the day, and extra suggestions for consideration.

The overall aim is to grow and mould these events to become an annual occurrence for teams and wards, and an opportunity for staff and/or patients to initiate those important conversations around culture, identity, and overall knowledge and competence that reflects the population CNTW serves.

Each of the events that took place across the Trust incorporated anonymous comment boxes for feedback and suggestions for future events. Comments received via anonymous comment boxes reflected the following key points:

- "Brilliant event, absolutely enjoyed it. Hoping for more such events for a positive break from hectic routine"
- "Absolutely amazing experience and a definite eye opener. Such a brilliant way to learn more about your colleagues"
- "Today has been a great day, we all enjoyed ourselves and seeing everyone together is lovely. Hope we will do this again"
- "I had a great time and looking forward to more of such events on the ward"
- "What a fabulous event, lots of food and different cultures. Amazing!"
- "What an amazing event. Everyone looked stunning and really enjoyed their dancing and food. Well done"
- "Really lovely day – enjoyed learning about everyone's traditions and generally spending time with the team out with a working day."

Workforce Disability Equality Standard (WDES) Innovation Fund

The Trust was awarded £10,000 funding at the start of 2023 by NHS England to develop a set of resources for disabled staff and their managers. The Equality Diversity and Inclusion Team worked during 2023-24 with our Disabled Staff Network, colleagues from Workforce and Organisational Development and Informatics in conjunction with local disability-led charity, Difference, to develop interactive intranet-based toolkits – one specifically for disabled staff, the other for their managers. The project has been an excellent example of coproduction and as we publish this report the toolkits have been finalised and built on the intranet in advance of an official launch in May 2024.

Content across the staff and manager toolkits includes:

- Process for Requesting Reasonable Adjustments
- Completing the Disabled Staff Passport
- What is disability … Am I disabled?
- Hidden & Obvious Impairments
- Disability Identity & Language
- Definitions of Disability
- What is Neurodiversity?
- Reasonable Adjustments
- Why We Must Increase Accessibility at Work
- Talking About Disability, Wellbeing & Reasonable Adjustments
- Things to Consider When Talking About Disability With Staff
- Making Training More Accessible
- Changing Someone's Working Arrangements
- Finding a Different Way to Do Something
- Providing Equipment, Services or Support
- Reasonable Adjustments for Absence
- Disability-Related Leave
- Disability Identity & Language
- A-Z of Workplace Adjustments
- Frequently asked questions

Family Support Programme for the Farsi Community

One of our Forensic Child and Adolescent Psychiatrists at CNTW and Chair of Iranian Diaspora Association of Psychiatrists arranged a free series of parenting programmes for the Farsi community. He collaborated with a wide range of subject experts and delivered 10 sessions to support Iranian families and their children across January to March 2024. This fantastic programme was aligned to CNTW's strategic ambition to reach out to those who need mental health support in the communities we serve.

Each session covered different topics to help identify, address, and support various aspects of a child's life. Topics included how to support children who are struggling with anxiety, depression, bullying, psychological trauma, ADHD, Autism, self-harming, substance abuse, violent and aggressive behaviour, and parenting approaches to help build a better future for children. Each session included specialist guest speakers, role-playing scenarios guided by multi-professional teams, and allowed families the opportunity to have any questions

answered. The programme was delivered both in person at Walkergate Park Hospital and online via a virtual link, allowing increased accessibility for the community.

The tenth and final session took place on 21 March 2024, which combined a celebration of Nowruz (Persian New Year) and career conversations for children.

Culture Lab

The International Recruitment Team, alongside the Equality, Diversity and Inclusion Team, workforce representatives, and Cultural Diversity Network have introduced a Culture Lab. This came out of the Accelerated Development Project in partnership with North Cumbria Integrated Care (NCIC), who have already implemented a Culture Lab within their Trust. The Culture Lab is created by staff, for staff – it represents the wonderful diversity of our staff and encourages conversation starters between colleagues. The Culture Lab provides lived-experience information on the countries our staff come from, allowing a more personal touch when learning about different cultures.

All staff are actively encouraged to contribute to the Culture Lab, and it will be regularly updated to represent our increasingly diverse workforce. So far, there are 20 submissions and counting.

Workforce Race Equality Standard (WRES)

The most recent CNTW WRES and WDES Annual Report (22/23) was published in August 2023. The data compiled within this report is from a snapshot taken on 31 March 2023, as well as findings from the NHS Staff Survey which took place in Autumn 2022.

CNTW WRES 2023 Key Findings:

- Black & Minority Ethnic (BME) staff made up 9.06% of the total CNTW workforce.
- 3.2% of staff in non-clinical roles were from BME background and 82.5% were employed at band 5 or below, 77% of White non-clinical staff were employed at band 5 or below.
- 8.6% of staff in clinical (non-medical) roles were from BME background and 73.5% were employed at band 5 or below, 47.6% of White clinical staff were employed at band 5 or below.
- 50.2% of medical staff were from BME background with 43.1% employed at Consultant Grade and 56.8% of White doctors employed at Consultant Grade.
- White job applicants are 2.12 times more likely to be appointed from shortlisting compared to BME applicants (down from 2.5 in 2022).
- BME members of staff are 1.57 times more likely to be in a formal disciplinary process compared to White staff (down from 2.69 in 2022).

CNTW WRES 2023 Recommendations:

- Continue Trust-wide rollout of Respectful Resolution Framework.
- Implement ongoing support package for Cultural Ambassadors in partnership with Capsticks to continue overall improvement for staff entering formal disciplinary processes.

- Trust Board to review relevant data, identify EDI areas of concern, and prioritise EDI actions in annual appraisals.
- Develop a Race Pay Gap Report to identify actions and eliminate race pay gaps.
- Develop centralised Cultural Competency and Awareness training package to create inclusive team cultures and ensure psychological safety.
- Launch awareness/allyship initiatives.

Workforce Disability Equality Standard (WDES)

The most recent CNTW WRES and WDES Annual Report (22/23) was published in August 2023. The data compiled within this report is from a snapshot taken on 31 March 2023, as well as findings from the NHS Staff Survey which took place in Autumn 2022.

CNTW WDES 2023 Key Findings:

- Disabled staff made up 8.2% of the total CNTW workforce from ESR data, despite 33.5% of staff stating they live with a long-term condition in the NHS Staff Survey.
- The recruitment of non-disabled staff to disabled staff when expressed as a ratio is 0.54:1. Disabled applicants are more likely to be appointed compared to non-disabled shortlisted candidates (the ratio was 0.91:1 in 2022).
- All figures for bullying and harassment by patients, public, colleagues, or managers experienced by disabled staff demonstrate an improvement over the last 2 reporting periods.
- There are more disabled staff employed at band 5 or below in both clinical and non-clinical roles. There are more non-disabled medical staff at consultant grade than disabled staff.
- 81.9% of disabled staff said adequate adjustments to carry out their work were made by the Trust (an improvement over the last 2 reporting periods).
- There was a 5.1 percentage point decrease in disabled staff believing the organisation provides equal opportunities for career progression, compared to the last reporting period.

CNTW WDES 2023 Recommendations:

- Develop Managers' Toolkit for staff with disabilities and reasonable adjustments (WDES Innovation Fund).
- Specialist training for HR Staff (WDES Innovation Fund).
- Trust Board to review relevant data, identify EDI areas of concern, and prioritise EDI actions in annual appraisals.
- Review flexible working policy.
- Develop and implement an improvement plan to address health inequalities within the workforce.
- Work with Capsticks to improve availability of data for capability measures.

National WRES & WDES Benchmark

The data in this report is taken from the NHS England Workforce Race Equality and Disability Equality Standards 2023 Analysis Report, which gives a national picture across all NHS Trusts. The data is compiled from a snapshot as of 31 March 2023, and responses from the NHS Staff Survey 2022.

NHS England WRES 2023 Key Findings:

- 26.4% of the workforce across NHS Trusts are BME (an increase of 13% from last year).
- The North East and Yorkshire region has a 15.8% BME workforce.
- Across all staff groups, the highest proportion of BME staff (38.5%) are employed at band 5, with the lowest proportion of BME staff (11.2%) employed at band 9 or VSM. However, 6% of staff at VSM level did not disclose their ethnicity.
- Across non-clinical staff groups, the largest proportion of BME staff (19.8%) are employed at band 6, with the lowest proportion of BME staff (10.7%) employed at VSM.
- Across clinical staff groups, the largest proportion of BME staff (41.6%) are employed at band 5, with the lowest proportion of BME staff (11.7%) were employed at band 8D (13.3% VSM).
- Across medical staff groups, the BME representation is 46.8%. Of 129,143 medical staff, 40.5% BME staff were employed at Consultant grade, with 53.3% white staff employed at Consultant grade.
- Nationally, white staff are 1.59 times more likely to be appointed from shortlisting compared to BME applicants.
- Nationally, BME staff are 1.03 times more likely to enter formal disciplinary processes compared to white staff.
- According to the NHS Staff Survey 2022 results, more BME staff (30.4%) than white staff (26.8%) experienced bullying, harassment or abuse from patients, relatives or the public in the last 12 months.
- According to the NHS Staff Survey 2022 results, 16.6% BME staff experienced discrimination from other staff in the last 12 months, compared to 6.7% white staff.
- 10.8% executive directors recorded their ethnicity as BME, an increase from 9.7% in 2022 and 8.9% in 2021.
- 20.3% non-executive directors recorded their ethnicity as BME, an increase from 18.4% in 2022 and 16.2% in 2021.

NHS England WDES 2023 Key Findings:

- Across all NHS Trusts, only 4.9% of staff reported having a disability on ESR (Electronic Staff Record), however 23.4% staff reported having a long-term illness or condition in the NHS Staff Survey 2022.
- Across all NHS Trusts, the disability status of 16.6% staff is ‘unknown’. This encompasses a declaration of ‘prefer not to answer’, ‘not declared’, or ‘unspecified’.
- In the North East & Yorkshire region, the declaration rate was slightly higher (5.1% on ESR and 26.1% on NHS Staff Survey 2022).
- According to the NHS Staff Survey 2022, more disabled staff than non-disabled staff reported experiencing harassment, bullying or abuse from patients and the public (7.2% disparity), managers (6.9% disparity), and other staff (8.3% disparity).

- The relative likelihood of disabled staff being appointed from shortlisting is 0.99, which means disabled staff were slightly more favoured over non-disabled staff (1.0 represents equity).
- In 2023, the disability declaration rate for band 8C and above was 3.9%, and 5.2% for bands below 8C. 5.7% of board members declared a disability.
- Disabled staff were 2.17 times more likely to enter a formal capability process on the grounds of performance, compared to non-disabled staff.
- According to the NHS Staff Survey 2022, 52.1% disabled staff and 57.7% non-disabled staff believe their organisation provides equal career progression or promotion, slightly higher than the previous reporting period.
- 27.7% disabled staff said they felt pressure from their manager to come to work, despite not feeling well enough (compared to 19.9% non-disabled staff). This is a marginal improvement from the last reporting period.
- 73.4% disabled staff said their employer made workplace reasonable adjustments to enable them to carry out their work.

Gender Pay Gap 2023

The Trust Gender Pay Gap 2022-23 Report was taken to the People Committee in January 2024. The report fulfils legislative requirements and sets out what the Trust is doing to close the gender pay gap. The figures for the 6 metrics we are required to report on for 2022-2023 (based on 31 March snapshot) are as follows:

- Mean gender pay gap is 11.56% - a decrease of 0.84% points on 2021-2022.
- Median gender pay gap is 0.54% - a decrease of 1.66% points on 2021-2022.
- Percentage of men and women receiving bonus pay is 2.0% men and 0.5% women (these figures remain the same from 2021-2022 data).
- Mean (average) gender pay gap using bonus pay is 10.99% - up from 9.6% in 2021-2022.
- Median gender pay gap using bonus pay is 39.35% - up from 31.3% in 2021-2022.
- Percentage of men and women in each hourly pay quartile:

	CNTW Figures of 2022-2023		**CNTW Figures for 2021-2022**		**CNTW Figures for 2020-2021**	
	Male	Female	Male	Female	Male	Female
Top quartile	26.83%	73.17%	27.7%	72.3%	29.0%	71.0%
Upper middle	19.79%	80.21%	20.0%	80.0%	21.6%	78.4%
Lower middle	26.03%	73.97%	27.4%	72.6%	26.6%	73.4%
Lower quartile	20.84%	79.16%	19.3%	80.7%	20.6%	79.4%

Equality, Diversity & Inclusion Objectives 2024-2025

In November 2023 we set three key objectives for the coming year. These are:

- A programme of actions to address progression within the Trust for staff protected under the Equality Act 2010. We know from analysis of our Workforce Race and

Disability Equality Standards that the distribution of staff from these protected characteristics is skewed towards Agenda for Change Bands 5 and below.

- Actions to eliminate the conditions in which bullying, discrimination, harassment and physical violence at work occur. Our staff survey results regularly show a gap between the experiences of staff that have a protected characteristic and those who do not. The challenge is therefore to eliminate the gap between the experiences of staff, whilst bringing down the overall levels of bullying, discrimination, harassment and physical violence. We will utilise techniques highlighted as best practice in the EDI Improvement Plan Repository on NHS Futures and build upon existing work taking place within the Trust – particularly to extend the pilot work on Hate Crime, Safe Spaces and Cultural Allyship Trust-wide.
- A baseline assessment to establish how we will engage with racialised and ethnic minority communities to identify and agree core organisational competencies requiring further development, then agree measurable and practical actions to develop them in local plans.

These objectives and actions have been determined by a mapping exercise of our existing position to two national initiatives that have been launch in the last year, the NHS Equality, Diversity and Inclusion Improvement Plan and the Patient Carer Race Equality Framework.

The NHS Equality, Diversity and Inclusion (EDI) Improvement Plan was launched in June 2023 by NHS England. It sets out targeted actions to address the prejudice and discrimination, direct and indirect, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. It is based on the premise that equality, diversity and inclusion is a key foundation for creating a caring, efficient, productive and safe NHS. It details 6 High Impact Actions required to make the changes that NHS staff and patients expect and deserve and who is accountable and responsible for their delivery. It outlines how NHS England will support implementation and a framework for integrated care boards to produce their own local plans.

The Patient Carer Race Equality Framework (PCREF) was one of the key recommendations of the Independent Review of the Mental Health Act (MHA). The MHA African and Caribbean group was established to support with the aims of the Independent Review, focusing on the inequalities faced by racialised and ethnically and culturally diverse communities. At its core, the PCREF aims to support NHS Mental Health Trusts to:

1. Improve their interaction with racialised and ethnically and culturally diverse communities.
2. Raise awareness of organisations' own cultural and racial bias and provide a framework to reduce them.
3. Improve governance, accountability, and leadership on improving experiences of care for racialised and ethnically and culturally diverse communities.

We look forward to being able to report progress on these important pieces of work in our next annual report.

Appendices

Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

	WHITE	BME	ETHNICITY UNKNOWN/NULL
Clinical workforce	**Verified figures**	**Verified figures**	**Verified figures**
Under Band 1	0	0	0
Band 1	1	0	0
Band 2	10	1	0
Band 3	1596	243	10
Band 4	369	24	3
Band 5	590	106	7
Band 6	1449	71	23
Band 7	895	39	7
Band 8A	269	14	4
Band 8B	110	7	1
Band 8C	77	3	1
Band 8D	19	1	0
Band 9	1	0	0
VSM	1	0	0
Consultants	116	88	0
of which Senior medical manager	0	1	0
Non-consultant career grade	27	52	0
Trainee grades	9	12	0
Other	0	0	0

Relative likelihood of staff being appointed from shortlisting across all posts

	WHITE	BME	ETHNICITY UNKNOWN/NULL
	Verified figures	Verified figures	Verified figures
Number of shortlisted applicants	4128	1339	0
Number appointed from shortlisting	1405	215	0
Relative likelihood of appointment from shortlisting	34.04%	16.06%	0%
Relative likelihood of White staff being appointed from shortlisting compared to BME staff	2.12		

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

	WHITE	BME	ETHNICITY UNKNOWN/NULL
Number of staff in workforce	7087	713	71
Number of staff entering the formal disciplinary process	76	12	0
Likelihood of staff entering the formal disciplinary process	1.07%	1.68%	0.00%
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		1.57	

Relative likelihood of staff accessing non-mandatory training and CPD

	WHITE	BME	ETHNICITY UNKNOWN/NULL
Number of staff in workforce	7087	713	71
Number of staff accessing non-mandatory training and CPD:	No figures provided for 2023.		
Likelihood of staff accessing non-mandatory training and CPD			
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff			

Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

	WHITE	ALL OTHER ETHNIC GROUPS
Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months	26.6%	36.2%
Total Responses	3269	229

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

	WHITE	ALL OTHER ETHNIC GROUPS
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	13.6%	24.1%
Total Responses	3262	228

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

	WHITE	ALL OTHER ETHNIC GROUPS
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	68.2%	50.2%
Total Responses	3239	225

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months

	WHITE	ALL OTHER ETHNIC GROUPS
Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months	4.8%	17.3%
Total Responses	3260	225

Percentage difference between the organisations' Board voting membership and its overall workforce

	White	BME	Unknown
Total Board Members	13	1	0
Voting Board Members	13	1	0
Exec	5	1	0
NED	8	0	0

Trust Board BME 7.7%
Trust Workforce BME 9.06%

Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

	Disabled	% Disabled	Non-disabled	% Non-disabled	Unknown/Null	% Unknown/Null	Total
1a) Non Clinical Staff							
Under Band 1	2	16.7%	9	75%	1	8.3%	12
Bands 1	0	0%	1	100%	0	0%	1
Bands 2	23	9.7%	198	83.2%	17	7.1%	238
Bands 3	44	8.6%	414	81.3%	51	10%	509
Bands 4	36	10.5%	288	84%	19	5.5%	343
Bands 5	20	10.3%	157	80.9%	17	8.8%	194
Bands 6	8	5.6%	118	82.5%	17	11.9%	143
Bands 7	3	3.8%	71	88.8%	6	7.5%	80
Bands 8a	6	11.5%	42	80.8%	4	7.7%	52
Bands 8b	0	0%	30	85.7%	5	14.3%	35
Bands 8c	0	0%	2	100%	0	0%	2
Bands 8d	0	0%	1	100%	0	0%	1
Bands 9	0	0%	1	100%	0	0%	1
VSM	4	100%	0	0%	0	0%	4
Other (e.g. Bank or Agency) Please specify in notes.							
Cluster 1: AfC Bands <1 to 4	105	9.5%	910	82.5%	88	8%	1103
Cluster 2: AfC bands 5 to 7	31	7.4%	346	83%	40	9.6%	417
Cluster 3: AfC bands 8a and 8b	6	6.9%	72	82.8%	9	10.3%	87
Cluster 4: AfC bands 8c to VSM	4	50%	4	50%	0	0%	8
Total Non-Clinical	146		1332		137		1615

Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

	Disabled	% Disabled	Non-disabled	% Non-disabled	Unknown/Null	% Unknown/Null	Total
1b) Clinical Staff							
Under Band 1	0	0%	0	0%	0	0%	0
Bands 1	1	100%	0	0%	0	0%	1
Bands 2	6	54.55%	5	45.45%	0	0%	11
Bands 3	136	7.36%	1435	77.61%	278	15.04%	1849
Bands 4	40	10.10%	326	82.32%	30	7.58%	396
Bands 5	63	8.96%	536	76.24%	104	14.79%	703
Bands 6	143	9.27%	1239	80.30%	161	10.43%	1543
Bands 7	69	7.33%	792	84.17%	80	8.50%	941
Bands 8a	20	6.97%	248	86.41%	19	6.62%	287
Bands 8b	1	0.85%	113	95.97%	4	3.39%	118
Bands 8c	1	1.23%	69	85.19%	11	13.58%	81
Bands 8d	3	15%	17	85%	0	0%	20
Bands 9	0	0%	1	100%	0	0%	1
VSM	0	0%	1	100%	0	0%	1
Other (e.g. Bank or Agency) Please specify in notes.	0		0		0		0
Cluster 1: AfC Bands <1 to 4	183	8.1%	1766	78.2%	308	13.6%	2257
Cluster 2: AfC bands 5 to 7	275	8.6%	2567	80.5%	345	10.8%	3187
Cluster 3: AfC bands 8a and 8b	21	5.2%	361	89.1%	23	5.7%	405
Cluster 4: AfC bands 8c to VSM	4	3.9%	88	85.4%	11	10.7%	103
Total Clinical	483	8.1%	4782	80.3%	687	11.5%	5952
Medical & Dental Staff, Consultants	11	5.42%	143	70.44%	49	24.14%	203
Medical & Dental Staff, Non-Consultants career grade	7	8.86%	58	73.42%	14	17.72%	79
Medical & Dental Staff, trainee grades	1	4.35%	19	82.61%	3	13.04%	23
Total Medical and Dental	19	6.23%	220	72.13%	66	21.64%	305
Number of staff in workforce	502		5002		753		6257

Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts

	Disabled	Non-disabled
Number of shortlisted applicants	647	14022
Number appointed from shortlisting	58	680
Likelihood of shortlisting/appointed	0.089	0.048
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	0.54	

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

	Disabled	Non-disabled
Total Number of Staff	No figures provided for 2023.	
Average number of staff entering the formal capability process over the last 2 years. (i.e. Total divided by 2.)		
Likelihood of staff entering the formal capability process		
Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		

Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

	Disabled	Non-disabled
Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months	30.5%	25.7%
Total Number of Responses	1172	2335

Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

	Disabled	Non-disabled
Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	8.1%	4.0%
Total Number of Responses	1171	2318

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

	Disabled	Non-disabled
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	15.8%	9.5%
Total Number of Responses	1166	2311

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

	Disabled	Non-disabled
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	71.8%	70.1%
Total Number of Responses	408	663

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion

	Disabled	Non-disabled
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	63.7%	68.8%
Total Number of Responses	1159	2314

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

	Disabled	Non-disabled
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	18.1%	11%
Total Number of Responses	746	964

Percentage of staff satisfied with the extent to which their organisation values their work

	Disabled	Non-disabled
Percentage of staff satisfied with the extent to which their organisation values their work	44.6%	54.1%
Total Number of Responses	1179	2329

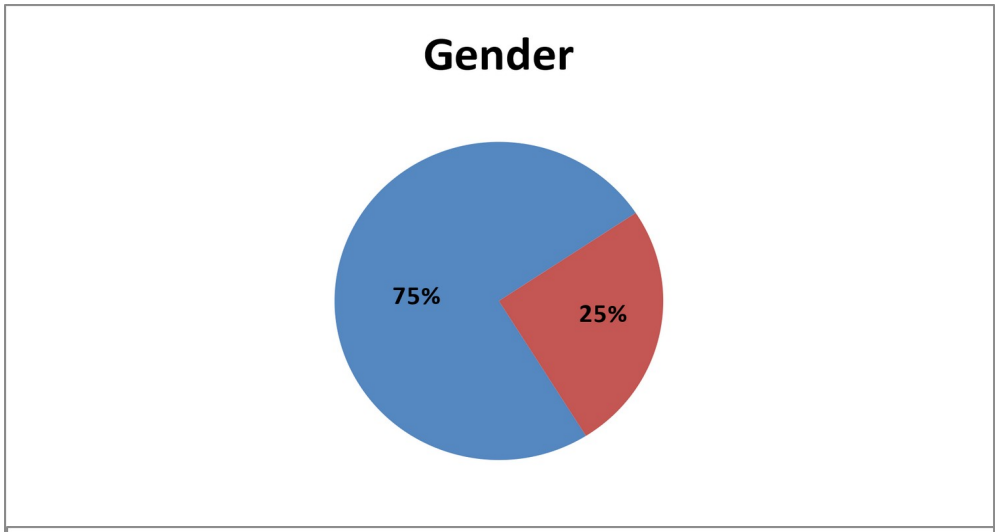
Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work

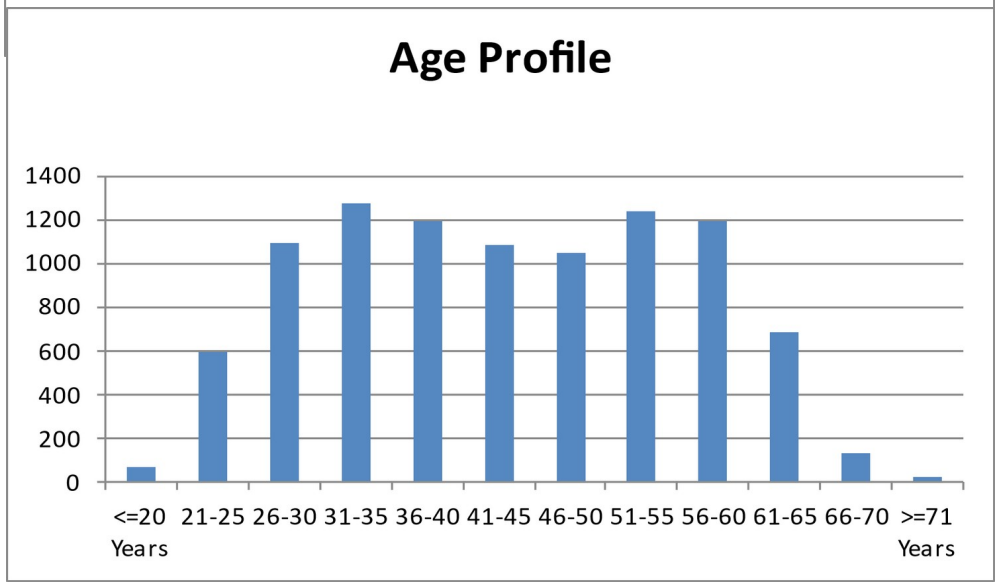
	Disabled
Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	81.9%
Total Number of Responses	701

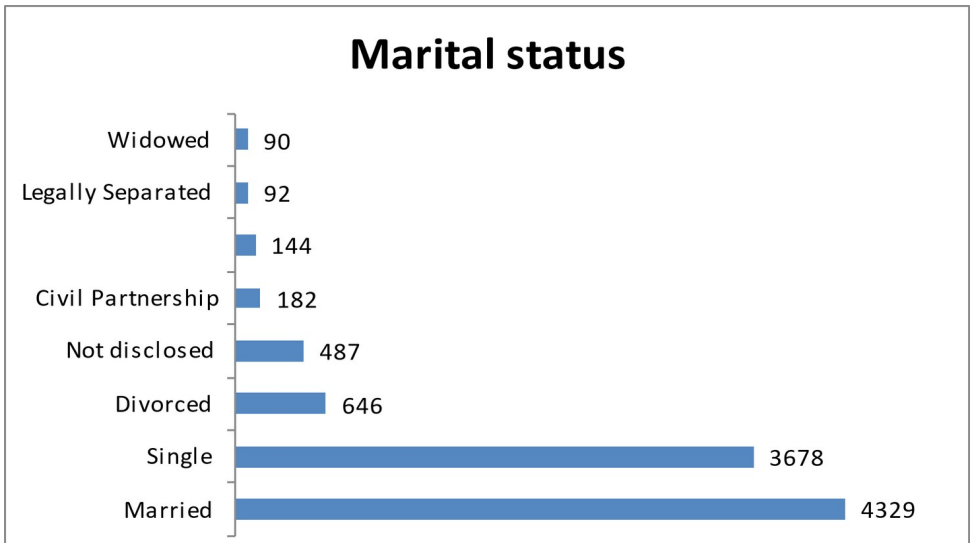
Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work

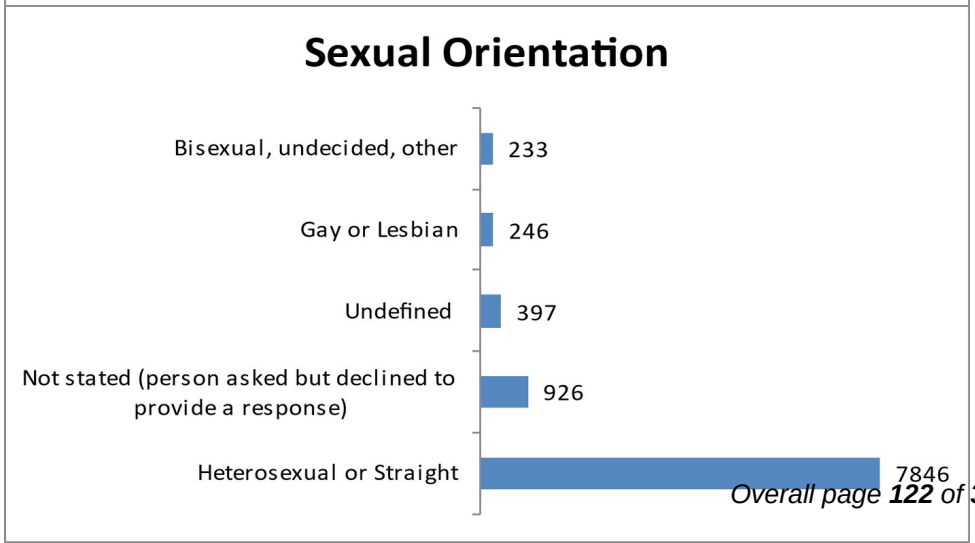
	Disabled	Non-disabled
Staff engagement score (0-10)	7.0	7.3
Total Number of Responses	1179	2338

2. Equality & Diversity Data as of 4 April 2024









3. Gender Pay Gap Data 2022-23

	CNTW Figures of 2022-2023		CNTW Figures for 2021-2022		CNTW Figures for 2020-2021	
	Male	Female	Male	Female	Male	Female
Top quartile	26.83%	73.17%	27.7%	72.3%	29.0%	71.0%
Upper middle	19.79%	80.21%	20.0%	80.0%	21.6%	78.4%
Lower middle	26.03%	73.97%	27.4%	72.6%	26.6%	73.4%
Lower quartile	20.84%	79.16%	19.3%	80.7%	20.6%	79.4%

Metric	CNTW Figures for 2022-2023	CNTW Figures for 2021- 2022	CNTW Figures for 2020-2021
Mean gender pay gap	11.56%	12.4%	13.2%
Median gender pay gap	0.54%	2.2%	3.4%

Metric	CNTW Figures of 2022-2023	CNTW Figures for 2021-2022	CNTW Figures for 2020-2021
The mean gender bonus gap: the % difference in average bonus payments made to male and female employees during the 12 month period to 31 March	10.99%	9.6%	22.3%
The median gender bonus gap: the % difference between the mid-point value of bonus payments made to male and female employees during the 12 month period to 31 March	39.35%	31.3%	55.9%
The proportions of relevant male and female employees who received bonus payments during the 12 month period to 31st March	2.0% Men	2.0% Men	2.2% Men
	0.5% Women	0.5% Women	0.6% Women

4.4 RAISING CONCERNS REPORT

Lynne Shaw, Executive Director of Workforce and OD

For Assurance

REFERENCES

Only PDFs are attached

4.4. Raising Concerns Whistleblowing Report Oct 23 - March 24.pdf

Name of Meeting	**Board of Directors**
Date of Meeting	**Wednesday 5 June 2024**
Title of Report	**Raising Concerns/Whistleblowing Report – October 2023 – March 2024**
Executive Lead	**Lynne Shaw, Executive Director of Workforce and OD**
Report author	**Gemma Rutherford, Deputy Director of Workforce and OD**

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

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

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

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

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA3 – A Great Place to Work Risk of poor staff motivation, engagement and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up.

Board of Directors
Wednesday 5 June 2024

Raising Concerns/Whistleblowing Report

1. Executive Summary

The purpose of this paper is to provide a summary of whistleblowing cases/concerns raised over the period from 1 October 2023 – 31 March 2024.

The paper aims to give an overview of cases reported centrally to the Workforce Team in line with the Trust's Raising Concerns Policy. Concerns raised with the Freedom to Speak Up Guardian (FTSUG) are also included. Additional concerns are raised and dealt with informally at a local level by operational managers and these concerns are not logged centrally.

In Sir Robert Francis' Freedom to Speak Up review it stated that not all concerns raised become subject to formal investigation under Raising Concerns or Grievance Policies. This is an approach welcomed and adopted by the Trust.

During the period identified, 62 issues have been raised via the FTSUG (60) and CQC (2). This is an increase compared to the previous period (37). The two CQC concerns related to Mitford and the Centre for Age and Vitality.

There is a trend in cases linked to Behaviour. This relates to managers, colleagues, and wider cultural issues. There is a theme where staff do not feel supported at work.

2. Risks and mitigations associated with the report

The Trust ensures all concerns raised are reviewed robustly and where required undertakes formal investigations.

3. Summary

The Trust has had for a number of years a clear, defined process for recording cases that fall under the scope of a policy such as whistleblowing (raising concerns), disciplinary or grievance, however, there are a number of concerns raised which do not meet the Disclosure Act's definition of whistleblowing. In these instances, the Trust has developed a separate recording category called "raising concerns" for reporting purposes.

Concerns which have been raised through the disciplinary and grievance procedures are not included within this report.

4. Recommendation

The Board is asked to note the report.

Themes

Summary of Cases Logged Centrally and with FTSUG 1 October 2023 – 31 March 2024

Type of Case	Concern	Whistleblowing
Attitudes and Values	5	0
Behaviour	2	0
Behaviour of Management	11	0
Bullying and Harassment	5	0
Concerns relating to protected characteristic	3	0
Culture	8	0
Issues with care of family member by CNTW	3	0
Policies and Procedure	11	0
Safety	3	2
Unknown	7	0
Working hours	2	0
Total	**60**	**2**

Behaviours

The main themes from raising concerns during this period are predominantly linked to the behaviour of management which is a new theme since the last report. Under this umbrella of behaviour, it can also include the themes of attitudes and values and bullying and harassment.

The Trust has Management skills training available for managers and supervisors as some of the concerns are related to effective communication and having difficult conversations.

All managers at Bands 8a and above will now receive a copy of the NHS Managers Code of conduct and this will be included as a contractual requirement for all new managers.

The Trust has adopted a respectful resolution approach with training being rolled out. The aim is to have workplaces where staff feel respected and supported, positive behaviours are encouraged, modelled and appreciated. This approach also looks to support staff to safely challenge negative behaviour.

Policy and Procedures

Many of the concerns raised regarding policies and procedures are linked to employee relations processes. For example, where a staff member has had a restriction placed on them whilst undergoing a disciplinary process.

The Trust has changed its approach to triaging employee relations cases and as such the number of cases overall continues to reduce. Monitoring of employee relations cases is via Business Delivery Group – Workforce. The Trust is working towards a more Just Culture style which embraces open and honest reporting where the Trust can learn and develop.

In terms of timescales for employee relations, the Trust is putting in place a rota for hearings and appeals to reduce the length of time these take to be arranged. This is planned to be in place from June/July 2024 and will have Group Directors and Associate Directors on the rota; it will also include Corporate Services Managers.

Safety
Of the five concerns raised regarding patient safety, two have been received via the CQC including concerns relating to Mitford and the Centre for Age and Vitality.

The concerns relating to Mitford have seen a comprehensive management response with wider stakeholders such as the FTSUGs and Staff Side.

The concerns relating to the Centre for Age and Vitality are currently being investigated by a Senior Nurse.

The Trust continues to support the use of body warn cameras as well as CCTV.

Areas where concerns have been raised

Area	Concern	Whistleblowing
Community	27	
Corporate	1	
Inpatients	9	1
NTW Solutions	1	
Specialist	16	1
Unknown	5	
Withheld	1	
Total	**60**	**2**

It can be noted the highest number of concerns raised via the FTSUG is in Community services, there is also a trend noted by the Guardians within Cumbria.

Specialist services sees the next highest area of concerns raised. This is linked to the ongoing work at Mitford.

Role of Guardians

The Guardians have sought to help staff resolve issues themselves without them having to escalate the issue. This may be through encouraging conversations to take place with managers, signposting staff to utilise existing processes and support mechanisms available or providing some confidence and reassurance to staff.

Communications are ongoing to raise the profile of the two FTSUGs who are working with the FTSU Champions to ensure staff across the Trust can access support and understand where and how they can raise concerns.

The Guardians report an increase in staff members wishing to remain confidential through a speaking up process. There is a concern this could be an indication of a negative speaking up culture within the Trust.

Feedback from the Guardians is that there continues to be a feeling that some staff will not raise concerns for fear of repercussions or staff have apathy at raising a concern feeling

nothing will be done. The Guardians recommend that further work should be undertaken within the Trust to understand the root cause of this and develop strategies to address this.

This is currently being considered and will be a discussion topic at a future Trust Leadership Forum.

The number of cases raised in this reporting period has increased significantly, 60 cases compared to 37 in the last reporting period. The FTSUGs have been allocated 19.5 hours per week to dedicate to working on FTSU activity including supporting staff and raising the profile of the role. There are ongoing regular meetings with the FTSUGs and the Executive Director of Workforce and Organisational Development to discuss themes and agree actions to resolve.

Gemma Rutherford
Deputy Director Workforce & OD

Lynne Shaw
Executive Director Workforce & OD

22 April 2024

4.5 STAFF SURVEY 2023 REPORT

Lynne Shaw, Executive Director of Workforce and OD

For Assurance

REFERENCES

Only PDFs are attached

4.5 Staff Survey 2023 - Board copy.pdf

2023 NHS Staff Survey

Summary of Results

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Kim Carter – Acting Head of Workforce Developments

National Headlines – Trends

- Response rate 48% - up from 46% in 2022 (94% of responses were online)
- 61.12% would recommend their organisation as a place to work – 3.7% increase from last year however remains below the level reported in 2019 and 2020
- 31.23% of staff were satisfied with their level of pay – increase of 5.62% from 2022
- 71.95% said they receive the respect they deserve from their colleagues at work – this remains the highest amongst staff working in Mental Health & Learning Disability Trusts (77.10%)
- Satisfaction of flexible working opportunities remains the highest amongst staff working in Mental Health & Learning Disability Trusts (67.37%).
- 29.12% of staff said they think about leaving their organisation – has improved this year but remains worse than 2020 (26.58%)

National Headlines – Trends

Organisation type	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
National Average	7.30	6.00	6.72	-	5.64	6.28	6.80	6.89	5.95
Acute and Acute & Community	7.23	5.91	6.67	-	5.59	6.17	6.72	6.86	5.90
Acute Specialist	7.55	6.13	6.93	-	5.79	6.40	6.93	7.29	6.14
MH & LD and MH, LD & Community	7.58	6.43	6.98	-	5.92	6.83	7.17	7.11	6.18
Community	7.71	6.42	7.12	-	6.00	6.87	7.18	7.23	6.20
Ambulance	6.80	5.30	5.93	-	4.85	5.33	6.16	6.01	5.52

CNTW Headlines

- Response rate of 41% - decrease of 6% on last year. The Picker average response rate for similar organisations* was 52%

- This was the first fully online survey

- The survey opened on 21 September 2023 and closed on 24 November 2023

*Picker was commissioned by 23 Mental Health and Mental Health Community Trust organisations – results are in comparison to those organisations

CNTW Headlines (Former FFT Scores)

- ‘I would recommend my organisation as a place to work’, has decreased to 63% from 65.1% in 2022 and 64% in 2021

- ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation’ has remained static at 65% which is the same as 2022 but is a decrease from 67.1% in 2021

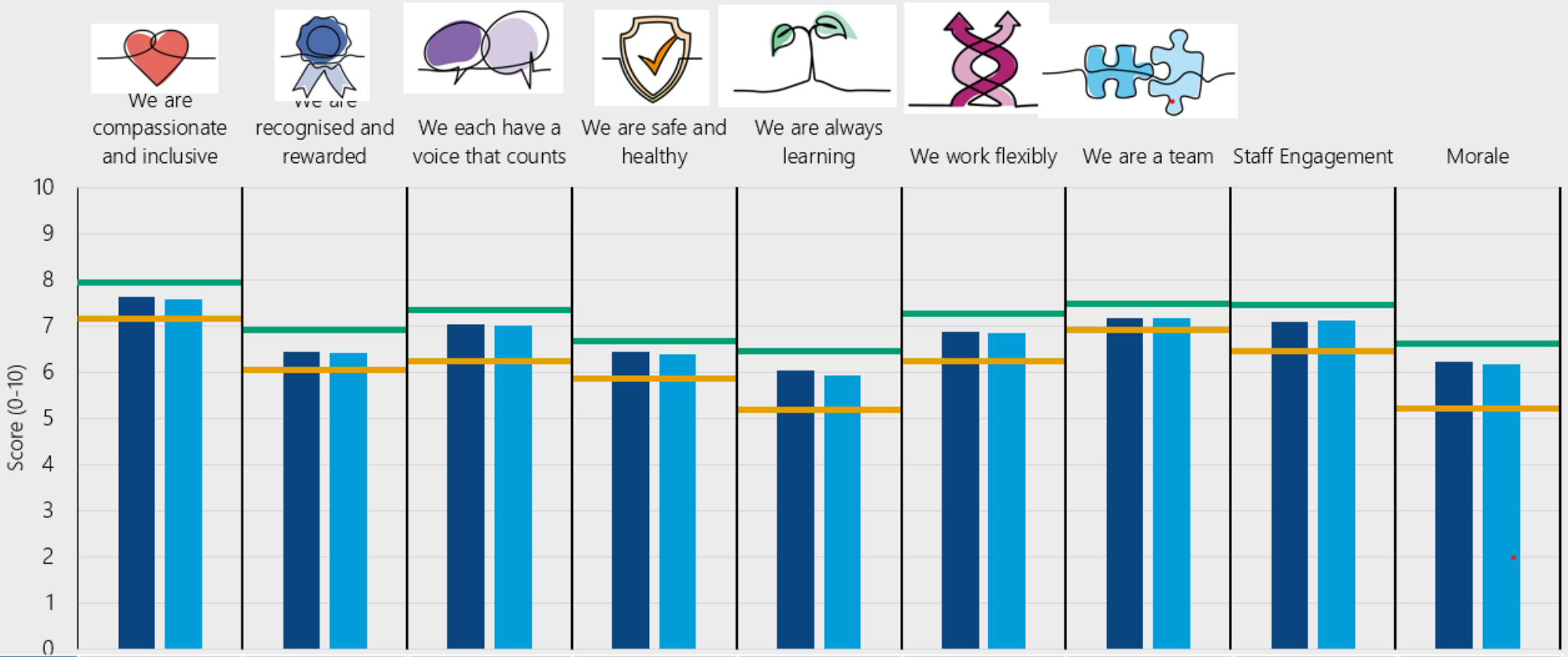
- ‘There are enough staff at this organisation to do my job properly’ has increased from 29.9% in 2022 to 32.6% in 2023

People Promise elements and themes: Overview

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.63	6.44	7.03	6.44	6.03	6.86	7.15	7.09	6.23
Best result	7.93	6.90	7.34	6.68	6.45	7.25	7.47	7.45	6.61
Average result	7.58	6.41	7.01	6.38	5.93	6.84	7.18	7.11	6.17
Worst result	7.14	6.04	6.23	5.84	5.17	6.23	6.90	6.46	5.21
Responses	3296	3294	3281	3282	3146	3282	3296	3297	3299

CNTW Results

Areas of concern

The following areas have seen a decrease from 2022 results which had previously been the areas to celebrate

- Staff feeling safe to speak up regarding concerns (73.1% in 2022 compared to 68.8% in 2023)
- Staff being treated fairly involved in error/near miss/ incidents (57% in 2022 compared to 55.1% in 2023)
- Opportunities for career development (64.9% in 2022 compared to 59.6% in 2023)
- Teams having enough freedom in how to do their work (60.2% in 2022 compared to 58% in 2023)
- The organisation taking positive action on health and wellbeing (68.5% in 2022 to 63.3% in 2023)

CNTW Results

Areas we have improved on

We are close to benchmark average* on all elements of the People Promise which is a similar theme witnessed in 2022

- Staff feeling satisfied with their level of pay has increased (31.6% in 2022 compared to 37.7% in 2023)
- Reduction in physical violence from patients (77.9% in 2022 compared to 81.8% in 2023) and remained static from manager (99.6% in 2023) and colleagues (99.1% in 2023)
- Increased views that there are enough staff at the organisation (29.9% in 2022 compared to 32.6% in 2023) resulting in staff working less paid and unpaid overtime
- Appraisals supporting job improvement (23.8% in 2022 compared to 26.6% in 2023)

*Picker was commissioned by 23 Mental Health and Mental Health Community Trust organisations – results are in comparison to those organisations

CNTW Results Top 5 scores

Top 5 scores vs Organisation Average	Org	Picker Ave
Last experience of harassment/bullying/abuse reported	69%	62%
Last experience of physical violence reported	95%	88%
Organisation ensures errors/near misses/incidents do not repeat	74%	69%
Organisation acts fairly: career progression	63%	58%
Organisation acts on concerns raised by patients/service users	79%	74%

CNTW Results bottom 5 scores

Bottom 5 scores vs Organisation Average	Org	Picker Ave
Team has enough freedom in how to do its work	58%	63%
Staff involved in an error/near miss/incident treated fairly	55%	59%
Not experienced physical violence from patients/service users, their relatives or other members of the public	82%	86%
Satisfied with the extent organisation values my work	49%	52%
Time often/always passes quickly when I'm working	73%	75%

What is underway to support…

- Kindness and Respect (values) – our culture
- PSIRF/Just Culture
- FTSU Review
- Refresh of grievance process
- WRES/WDES and EDI refresh and review
- ESR project - strengthen reporting on exit/leavers, flexible working, quality of appraisal and wellbeing conversations to enable ‘hot spots’ to identify additional support

Work Ongoing

- Continued communication to staff from previous Staff Surveys and Quarterly Staff Survey results around the themes of the People Promise (you said we did)
- Line Manager guides for initiatives relating to action the results of the staff survey, flexible working, wellbeing and retention (e.g. Stay Conversations)
- Launch of the new Staff Survey Dashboard to enable full transparency of results
- Improvements to inclusive recruitment
- Review of Appraisal policy to support embedding of ‘With You in Mind’ values

Headlines from Bank Survey

- 109 staff responded (approximately 20% of bank staff) – higher than national average
- 82% of workers who responded to the survey are enthusiastic about their job
- 81% feel they achieve a good balance between work and home life
- 93% feel their role makes a difference to patients and service users
- 85% agree that the care of patients and service users is the Trust's top priority
- 93% agree they know what their work responsibilities are

Areas of focus

- Difference in work experience of registered and unregistered workers
- Perceived lack of development opportunities for workers
- Continue work around improving the work experience for BME workers

Key aims for the year ahead

- Embed our approach to engagement with staff-starting with Trust Leadership Forum
- Ownership of the survey-why should we engage? What can we learn?
- Team centred approach
- Explore the areas which mean most to staff. We want to see improvement in key areas
  - Freedom to make decisions
  - Staff treated fairly
  - Experience of physical violence
  - Feeling valued by the organisation
  - Support from Line Managers

- Are there other key areas we want to improve?

4.6 INTEGRATED PERFORMANCE REPORT ? A GREAT PLACE TO WORK

Lynne Shaw, Executive Director of Workforce and OD

For Assurance

5. STRATEGIC AMBITION - SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERY DAY

Darren Best, Chair

5.1 FINANCE REPORT

Kevin Scollay, Executive Director of Finance

For Assurance

REFERENCES

Only PDFs are attached

5.1 2425 - BoD - Public - Mth 1 Finance Update FINAL.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 5th June 2024**
Title of report	**Month 1 Finance Report**
Executive Lead	**Kevin Scollay, Executive Director of Finance**
Report author	**Kevin Scollay, Executive Director of Finance**

Purpose of the report	
To note	
For assurance	**Provide assurance and inform of the financial position reported to ICB**
For discussion	**Inform discussion to support delivery of the Trust's financial commitment**
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			
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
2545 – Failure to deliver sustainable financial position, 1687 – Managing resources effectively, 1762 – Restrictions in capital expenditure

Month 1 Finance Report

1. Executive Summary

1.1 **At Month 1 the Trust has generated a £2.5m deficit.**

1.2 This deficit is **in line with the financial plan at Month 1**. This plan is phased to deliver deficits in the first 9 months of the year and surpluses for the last quarter of the year.

1.3 At the end of Month 1 the Trust has spent £0.9m on agency staff against a plan £0.9m.

1.4 **Expenditure on the Trust capital programme is forecast to be £2.4m higher than the plan**. The Trust submitted a plan compliant with the CDEL limit allocated to the Trust. The trust planned delivery will breach the CDEL limit.

1.5 **The Trust has a cash balance of £38.6m** at the end of Month 1 which is behind the plan. Trust balances are planned to fall significantly through the year.

2. Key Financial Targets

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

Table 1

	Month 1		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit)	(£2.4m)	(£2.5m)	(£0.1m)
Agency Spend	£0.9m	£0.9m	(£0.0m)
Cash	£39.2m	£38.6m	£0.6m
Capital Spend	£1.0m	£0.7m	£0.3m

3. Financial Performance

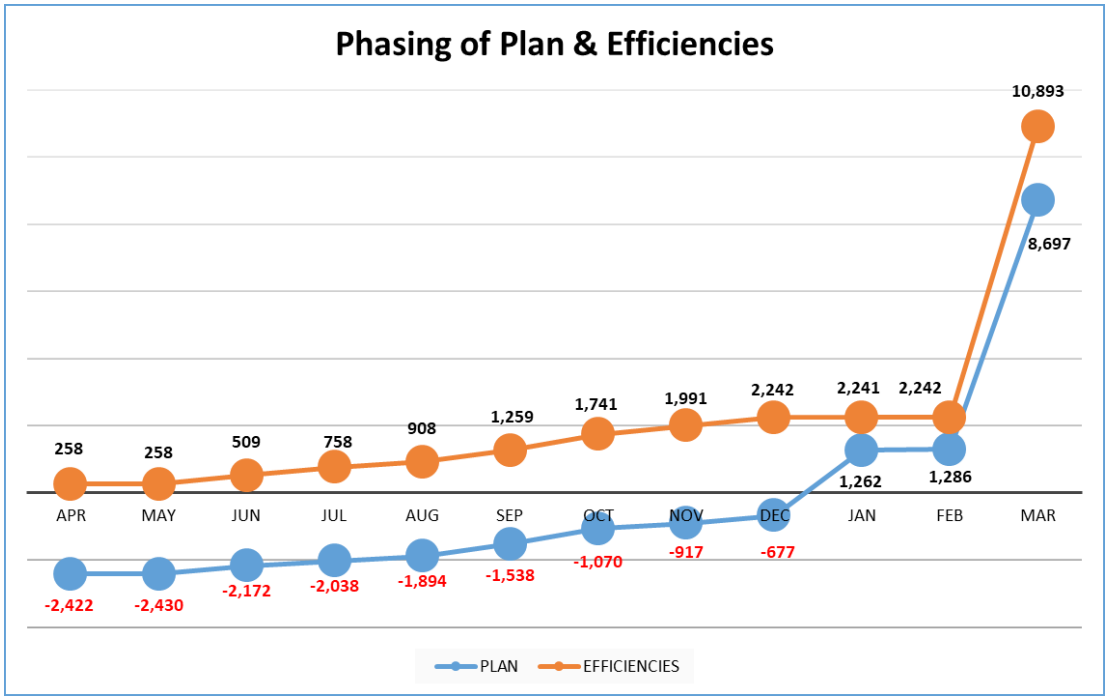
Income and Expenditure

3.1 At the end of Month 1 the Trust has reported a £2.5m deficit on Income and Expenditure, which is in line with the plan submitted to NHSE.

3.2 The Trust monthly planned deficit/surplus is shown in the graph below (blue line). The Trust is planning for deficits through Q1 to Q3 and then surpluses in Q4. The surpluses are generated from delivery of the trust efficiency plan. The graph below includes the phasing of the delivery of the efficiency plan (amber line). The significant increase in delivered efficiency in Month 12 reflects recognition of non-recurrent benefits (such as non-recurrent income) and a gain on disposal planned at the end of the year.

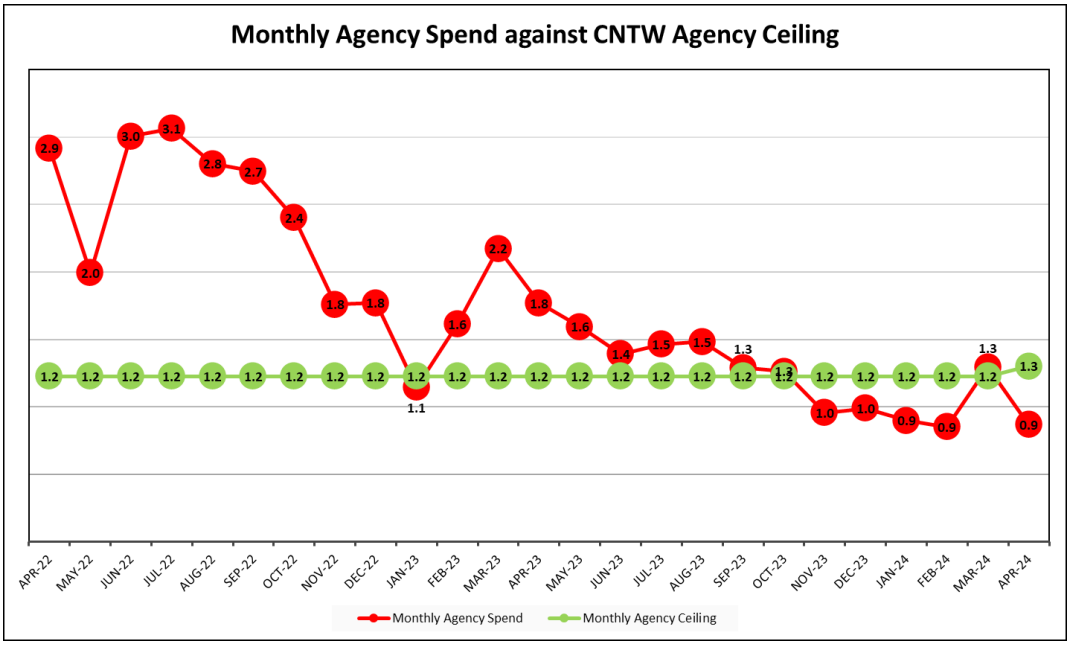
3.3 The trust plan includes £6.2m unidentified efficiencies. The Trust does not have a detailed plan for delivery of these efficiencies at Month 1. It is expected that a plan will be available for the Month 2 closedown and will support an overall financial forecast to submit to the ICB and NHS England as part of the Month 2 reporting process.

Graph 1



3.4 Graph 1 below highlights the agency performance from April 22. The Trust has spend £0.9m on agency in April. This is below the expected agency ceiling for NHS Providers of 3.7% of the Trust paybill. Note the ceiling has increased to £1.3m a month in April reflecting the increase in staff costs for 24/25.

Graph 2



3.5 While the Trust has seen a signifincant reduction in agency staffing through 2023/24 the overall staffing numbers showed a very slight increase. Table 2 below shows the total wte staffing in April against the pre-COVID staffing levels (Dec 19), 24 months ago, 12 months ago and last month.

Total wte have reduced from last month by 20, with a reduction in substantive staff of 66 and agency staff of 53 offset by an increase in bank useage of 99 wte. The trust annual workforce plan identifies a reduction of over 450 wte in 24/25.

Table 2

	Dec-19	Apr-22	Apr-23	Mar-24	Apr-24	Change since last month	Change 12mth	Change 24mth	Change since Dec-19
COMMUNITY CARE GROUP	2,491	2,761	3,011	3,026	3,040	14	29	279	548
INPATIENT CARE GROUP	1,538	1,810	1,976	1,979	1,990	11	13	180	452
SPECIALIST CARE GROUP	1,809	1,772	1,954	1,912	1,920	9	-34	149	111
LOCALITY BASED MGT	34	42	48	50	0	-50	-48	-42	-34
CLINICAL SUPPORT	336	392	441	479	480	1	39	88	144
	6,209	6,777	7,430	7,445	7,430	-15	0	653	1,222
CORPORATE & OTHER	1,159	1,250	1,348	1,340	1,335	-5	-14	85	176
	7,367	**8,026**	**8,778**	**8,785**	**8,765**	**-20**	**-13**	**739**	**1,398**

	Dec-19	Apr-22	Apr-23	Mar-24	Apr-24	Change since last month	Change 12mth	Change 24mth	Change since Dec-19
TRUST PAY	6,798	7,368	8,090	8,233	8,167	-66	77	799	1,369
BANK	302	205	293	342	441	99	148	236	140
AGENCY	268	453	395	210	157	-53	-238	-297	-111
	7,367	**8,026**	**8,778**	**8,785**	**8,765**	**-20**	**-13**	**739**	**1,398**

4. Cash

Table 3

	Year To Date		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**
Cash	39.2	38.6	0.6

4.1 Cash balances at the end of April are a little below the plan. The Trust cash balances have reduced by £2.6m from the £41.2m reported at the end of March.

4.2 The Trust is on plan for I&E and has a small underspend on the capital programme which support cash balances the Trust has seen a £5.2m increase in debtors (monies owed to the Trust) while creditors (monie owed by the Trust) has remained consistent with last month. The increase in debtors has reduced cash balances in Month 1.

5. Capital & Asset Sales

5.1 The Trust capital spend at the end of month 1 is £0.3m behind plan.

5.2 The Trust forecast includes a risk of £2.4m over the planned capital programme (CDEL limit) submitted in the annual plan. This is due to the approval of the older people's services business case, which includes the unavoidable movement of services from the CAV site. The Trust continues to forecast slippage against the overall capital programme but is highly likely to overspend based on current information.

5.3 The risk to the Trust CDEL limit of £2.4m does not included several other risks being cited as pressure against the capital programme:

- S136 suite on the SNH site
- Community estate in North Cumbria which is likely to require significant investment
- Replacement of air conditioning system at Benton House
- Inflation attached to CEDAR currently being managed with contractors

Table 4

	Year To Date			Year End		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**	**Plan* (£m)**	**Forecast (£m)**	**Variance/ Rating (£m)**
Capital Spend	1.0	0.7	(0.3)	16.6	19.0	2.4
Asset Sales	0.0	0.0	(0.0)	6.4	6.4	(0.0)

6. Recommendations

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

5.2 ANNUAL PLAN AND PRIORITIES

Kevin Scollay, Executive Director of Finance

For Approval

REFERENCES

Only PDFs are attached

5.2a 2425 Annual Plan and Piorities.pdf

5.2b Appendix 1 - 2425Annual Plan Priorities.pdf

Name of meeting	**Extraordinary Board of Directors**
Date of Meeting	**Wednesday 5th June 2024**
Title of report	**Final Annual Plan - NHSE submissions and Trust Priorities 24/25**
Executive Lead	**Kevin Scollay, Executive Director of Finance & Digital**
Report author	**Chris Cressey, Deputy Director of Finance & Business Development**

Purpose of the report	
To note	
For assurance	**Provide assurance and inform of the financial position reported to ICB**
For discussion	**Inform discussion to support delivery of the Trust's financial commitment**
For decision	

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

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

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

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money	**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

Annual Planning 2024/25

1. Purpose

The purpose of this report is to update the Board of Directors on the latest position on annual planning as well as provide detail of the approved plan agreed at on 2nd May 2024. The Trust Annual Priorities as well as the Financial, Workforce and Activity Plans submitted to NHSE as part of the ICS wide submission on 2nd May 2024 are included in this paper.

2. Executive Summary:

- The Trust submitted a final version of the 2024/25 plan to the ICB on 25th April as well as a final version of the plan to NHS England on the 2nd May.
- Trust submitted final plan shows a £3.9m deficit against financial performance and a compliant capital programme delivering against the allocated ICB CDEL. The plan retains a position cash balance all year but shows a reduction of £24m in cash balances.
- Trust undertook a peer review of plan with ICB and provider colleague. The Trust did not agree to change the headline I&E deficit of £3.9m following this review.
- The Trust plan includes £6.2m unidentified efficiency.
- To deliver the conclusion of CEDAR and move Newcastle OPS service off the General site to St Nicholas Hospital the Trust capital programme is likely to breach the ICB allocated CDEL for 2024/25. The business case for the changes to the OPS has been approved by the Trust Board.
- Workforce and activity trajectories are included in this paper for final approval. The workforce trajectories include the efficiency ambition included within the plan.
- The Trust priorities were updated following previous discussions at Board and are included in Appendix 1. These were considered and approved at the Board Meeting on 2nd May 2024.

3. Financial Plan

Income and Expenditure

RBAC received a paper at the January meeting (31st January) providing details planning position and the Board have received updates relating to the submission of the draft plan provided to the ICB and NHSE on 14th March and 21st March respectively. The draft plan showed the Trust plan to deliver a headline £3.9m deficit.

It should be noted that the ICB are currently liaising with NHSE on the impact of changes in accounting practice relating to PFIs on the measurement of financial performance. The working assumption at the time of submission was this change would be neutralised, therefore the deficit plan to which the Trust will be held to account was assumed to be £3m. Discussions on this issue are ongoing. The position at time of writing (22nd May 2024) was that the NENC ICS

calculation of the PFI pressure of £20.1m had not been accepted and NHSE had proposed an adjustment of £14.3m. This position is still under discussion. This does not change the planned deficit for CNTW at this point (which remains at £3.9m). However, it is expected that NHSE will expect the ICS to find additional efficiencies to resolve this difference which may impact on the expectations placed upon providers within the ICS. This remains unresolved and so the position remains uncertain at the time of writing.

Since submission of the draft plan work has been ongoing to review all plans across the ICB with all providers being subject to a peer review process with the ICB and an independent Director of Finance from another Trust within the ICS.

The CNTW peer review meeting took place on 11th April. The session was attended by the Director of Finance, Deputy Director of Finance, Deputy Chief Operating Officer, Head of Performance and Senior Workforce Development Manager. The ICB had reviewed the Trust position and provided a review pack including a number of Key Lines of Enquiry. The keys areas of discussion where: -

- The Trust income reduction from 2023/24 to 2024/25 is higher than average across the ICB
- How the Trust Finance and Workforce plans triangulate – particularly in relation to WTEs.
- How agency performance can be maintained and improved upon.
- Whether the planned increase in non-pay expenditure is credible (explained by rising energy costs and the exit from a fixed contract)
- The Trust has a lower level of reported efficiency identified than the average across the ICB and it is lower than the total for 2023/24

The Trust responded to all the Key Lines of Enquiry and was commended on the quality of its responses. No changes to the draft plan were agreed at the peer review.

The table below shows a summary of the Trust I&E plan submitted.

Table 1: Summary I&E Plan for CNTW for 2024/25

	2024/25 (£m)
Patient Care Income	530.3
Non Patient Care Income	45.9
Pay Costs	(419.7)
Operating Expenses	(158.7)
Operating Surplus / (Deficit)	**(2.2)**
Financing Costs	(8.6)
Gain on Diposal	6.4
Corporation Tax	(0.4)
Surplus / (Deficit)	**(4.8)**
Adjust for capital donanted/granted/peppercorn rents	0.3
Adjust PFI impact back to UK GAAP	0.6
NHS measured Financial Performance	**(3.9)**

The I&E position is a £4.8m deficit, which adjusted based on allowed exclusions across the NHS the position against NHS financial performance is a £3.9m deficit. This is expected to be amended further to reflect the changes in PFI accounting once discussions between the ICB and NHSE have concluded on the treatment of changes in PFI accounting, though the board should note this position remains uncertain.

The table below shows a summary of the bridge from the reported underlying position in 2023/24 to the submitted plan for 2024/25: -

Table 2: Summary bridge from 23/24 underlying position to 24/25 plan

	Income £m	Exp £m	Deficit £m	
2023/24 Underlying	**(576.6)**	**598.8**	**22.2**	
Remove Non Recurrent	17.3	(3.5)	13.8	
2024/25 Settlement & Pressure	(5.0)	16.8	11.8	
2024/25 Recurrent Efficiency	(0.1)	(16.8)	(16.9)	
2024/25 Underlying	**(564.4)**	**595.3**	**30.9**	
2024/25 Non Recurrent Efficiency		(8.5)	(8.5)	(25.3)
2024/25 Underlying		(8.3)	(8.3)	(33.6)
Reinclude MH & LD SDF 23/24	(5.1)		(5.1)	
Excess Inflation & Pay Differential	(3.1)		(3.1)	
Provider Collab Benefit & Overage	(3.5)		(3.5)	
Living Wage & Discount Change		1.5	1.5	
2024/25 Submission	**(576.1)**	**580.0**	**3.9**	

The totals highlighted show the level of 'efficiency' included in the draft plan submission. The £25.2m was specifically cited in the efficiency plan within the draft submission. Discussion at the Peer Review meeting revolved around whether further technical or non-recurrent benefits could be included to improve the position further. £8.3m has been included on the plan over and above the efficiency plan.

Risks to delivery of the efficiency plan

Over half the efficiency is identified from non-recurrent benefits (of which £11m are non-cash transactions).

Almost 20% are from Inpatients relying on delivery against budget and reduced reliance on inpatient beds.

Corporate service efficiency targets have been devolved to individual directorates and directors have submitted a first cut of cost reductions has been reviewed. Directors are currently looking to maximise synergies between departments where services can be delivered more effectively with different configurations. This work is ongoing.

£6.2m of the total is unidentified, a range of options are being explored to deliver this target.

Delivery of ambitious cost reduction targets is also a risk. Containing costs within ward budgets is challenging and a key area of risk for 24/25. The Trust will keep this risk under review but maintains a position where safety of services remains paramount.

Continued Planning Discussions

The Trust identified breaking even as a Trust wide priority for 24/25. The current financial plan does not reflect this ambition. Work will continue post submission to mitigate risks associated with delivery and improve upon the current deficit plan. At the Trust Peer to Peer review the Trust Director of Finance identified a number of ongoing issues which potentially impact on the Trust current deficit:

- The Trust has a discussion with Spec Comm re support for stranded costs circa (£0.5m - £1m)
- The Trust received non-recurrent funding for Mitford patients in 2023/24 and no funding has been agreed for 2024/25 (£1.6m)
- Cumbria OATs are not funded – effectively funded from top up, as top up reversal occurs reveals underlying pressure from Cumbria transfer
- Lack of clarity on MHIS detail – the Trust has not received a clear understanding on the deployment of the MHIS within the ICS, or how this has affected allocation of resources within the ICS. It has not been demonstrated to the Trust that the MHIS has been met nor whether any has been withheld in a reserve, though this does not mean this is the case. The ICB has committed to sharing this detail and securing sign off from Mental Health Foundation Trust within the NENC ICS.
- Recurrent income position is vital to support medium term planning and 24/25 exit run rates, this requires clarification with the ICB.
- The Trust has committed to setting medium term financial recovery trajectories at service line level. The Trust will explore stretch targets to achieve breakeven within 24/25 as part of this work during Quarter 1.

At time of writing (22nd May 2024) the national NHS CFO and CEO were meeting with systems to confirm plans for 2024/25. It is understood that the meeting for NENC ICS was taking place during the week commencing 20th May 2024. At these meetings it is understood that plans will be finalised for systems along with any additional measures required at system level to deliver the operational plan. As the outcome of this meeting is unknown at the time of writing, the implications for the Trust, if any, are unknown.

Capital Plan

The Trust 5 year capital programme is a 5-year capital plan reflecting the agreed commitments and the approved allocations of resource to maintain the Trust asset base. The Trust has approved a business case to move the Older Peoples services from the CAV to St Nicholas hospital site. To accommodate this priority, the allocation of capital to maintain the Trust asset base (backlog maintenance) has been reduced in 2024/25. NTW Solutions have reviewed the revised capital allocations and are satisfied the associated risks can be managed, but do not recommend reducing the allocations beyond 2024/25. The Trust capital programme is summarised below: -

Table 3: CNTW Capital Plan

	2024/25	2025/26	2026/27	2027/28	2028/29
	£m	£m	£m	£m	£m
CEDAR	7.7	1.5	0.0	0.0	0.0
Newcastle OPS	3.2	2.2	0.0	0.0	0.0
Hadrian / Acorn	0.8	0.0	0.0	0.0	0.0
Benton House	0.9	0.0	0.0	0.0	0.0
Minor Schemes	0.5	0.0	0.0	0.0	0.0
CCTV/Refurbishment/Safety	1.6	1.5	2.5	2.4	2.4
Backlog	0.7	1.5	2.0	2.0	2.0
IT	0.7	0.8	0.8	0.8	0.8
Secure data environment	0.9	0.0	0.0	0.0	0.0
Unallocated	0.0	0.0	1.1	1.2	1.2
Lease Addition/Disposal/Reval	1.8	0.2	0.2	0.2	0.2
	19.0	**7.6**	**6.5**	**6.5**	**6.5**

The NHS review the financing of the Trust capital programme in context of the forecast capital expenditure and the commitments to service existing PFI and loan agreements. The Trust capital programme is financed from depreciation, external funding (PDC) and the benefit from any asset sales. The Trust aims to dispose of two plots of land in 2024/25. The table below summarises the financing of the 5-year plan included in the draft planning submission.

Table 4: Capital Financing

Capital Financing	2024/25 £m	2025/26 £m	2026/27 £m	2027/28 £m	2028/29 £m
Depreciation	(4.4)	(4.4)	(4.4)	(4.4)	(4.4)
PDC Funding CEDAR	(7.4)	(1.5)			
PDC Funding SDE	(0.9)				
Sale of Land	(6.8)				
MONEY TO SPEND	**(19.5)**	**(5.9)**	**(4.4)**	**(4.4)**	**(4.4)**
Capital Programme	19.0	7.6	6.5	6.5	6.5
Lease Addition/Disposal/Reval	(1.8)	(0.2)	(0.2)	(0.2)	(0.2)
CAPITAL COSTS	**17.2**	**7.5**	**6.4**	**6.4**	**6.4**
PFI Capital Payments	3.2	3.2	3.2	3.2	3.2
Loan Repayments	2.5	2.5	2.5	2.5	2.5
COMMITMENTS	**5.7**	**5.7**	**5.7**	**5.7**	**5.7**
TOTAL SPEND	**22.9**	**13.2**	**12.1**	**12.1**	**12.1**
SHORTFALL IN CASH	**3.4**	**7.3**	**7.7**	**7.7**	**7.7**

The table shows there is insufficient capital financing in-year to support the planned capital programme in 2024/25 and going forward. The Trust is forecasting to deliver a deficit from the I&E account in 2024/25, therefore there is no cash to support financing the capital programme. The cash balances (carried forward from previous years) will be required to mitigate the shortfall in funding in 2024/25.

In future years, the Trust is expected to have to deliver surpluses at c£7.7m to support the planned level of capital programme. This total has increased from previous years planning as the total forecast depreciation has reduced from revaluation of the Trust PFI and Right of Use assets. While this is advantageous from an I&E perspective it reduces the funding available to support the capital programme.

Capital Budgeting (Capital Department Expenditure Limit - CDEL)

The national NHS budget is split between an allocation for revenue and an allocation for capital. The capital total is allocated across ICBs and then to providers to set a limit (CDEL) to maintain the annual capital spending within the total national limit. Discussions have been ongoing with the ICB as the limit set for CNTW is insufficient to meet the capital programme proposed. The table below shows the Trust capital programme with the allowed adjustments against the CDEL allocated to CNTW for 2024/25.

Table 5: 24/25 Capital Programme and CDEL allocation

	2024/25
	£m
CAPITAL PROGRAMME	**19.0**
Remove Lease Adjustments	(1.8)
PDC - CEDAR	(7.4)
PDC - SDE	(0.9)
Net Book Value of Sales	(0.4)
TRUST TOTAL	**8.5**
TRUST ALLOCATED CDEL	**6.1**
OVER COMMITTED	**(2.4)**

The Trust capital programme is £2.4m over the allocated CDEL based on current commitments. Individual Trusts and systems collectively often observe high levels of slippage associated with their capital programmes, which can result in system wide underspends against capital budgets. The Trust has assumed slippage against its capital programme at this point and is keeping this position under close review.

Risks to delivery of capital within the CDEL envelope

The approval of the OPS creates a pressure on the CDEL envelope of £2.4m. There are a number of other risks inherent in the plan the Board of Directors should be aware of;

1. The development of a s136 suite on the SNH site – c£0.5m estimated risk.
2. Some estate in Cumbria is in urgent need of attention/replacement. C£0.5m estimated risk.
3. Replacement of the air conditioning system at Benton house also requires replacement. From a value for money perspective, it is likely that replacement of this during the 24/25 financial year is advantageous, rather than 25/26 when it was due to happen as this would avoid significant additional costs associated with working in a live building environment and 'making good' internal building finishes.
4. Inflation attached to key capital schemes is currently a risk to delivery within the CDEL envelope.

Balance Sheet & Cash Flow

The tables below show the Trust forecast balance sheet and cash flow included in the final submission: -

Table 6: Balance Sheet and Cash Flow Forecasts

FORECAST BALANCE SHEET 31/3/25	2024/25
	£m
Fixed Assets	211.15
Debtors	29.95
Cash	16.42
Creditors	(54.50)
Borrowings	(145.64)
Provisions	(7.02)
Deferred Income	(1.75)
Net Assets Employed	**48.61**
Public Dividend Capital	295.80
Revaluation Reserve	5.99
I&E Reserve	(253.17)
Total taxpayers Equity & Other Equity	**48.61**

FORECAST CASH FLOW 2024/25	2024/25
	£m
Opening Cash	**41.2**
I&E Position	(4.8)
Depreication	10.5
	0.0
Capital Programme	(14.8)
PDC Funding	8.3
	0.0
DoH Loan Repayments	(2.5)
RoU Asset Lease Payments	(4.0)
PFI Capital Repayment	(3.2)
Non Cash Transactions	(11.0)
Working Balances	(3.3)
CLOSING CASH	**16.4**

The Trust cash balances are forecast to remain positive through the year but reduce by over £24m. The financial position in I&E is supported by transactions which provide a benefit to the I&E account, but do not result in increases in cash balances. Also as advised above, the Trust capital plans need to be financed from cash balances generated in previous years. The Trust is also forecasting a deficit and has to meet the annual commitments for the PFI sites and Department of Health loans for previous capital builds. Following the trend forecast in 2024/25 the Trust will exhaust cash balances in early 2025/26.

Risks to the cash position

Although cash balances will be significantly reduced in 24/25, they are not expected to fall below zero and therefore trigger requirements to borrow from Treasury. This position is however at risk due to other risks inherent in the plan.

1. Risk of delivery of identified efficiency schemes – in the event these schemes do not deliver, or are delivered from non-cash initiatives, the cash position will be eroded.
2. Risk of not identifying cash releasing schemes to mitigate currently unidentified efficiency schemes. In the event these are not identified, cash will be affected alongside I&E risks already identified.
3. Capital plan – in the event a source of cash backed funding is not identified, or slippage does not materialise, the risks to the capital plan will manifest themselves in a reduced cash position too.

4. Workforce Plan

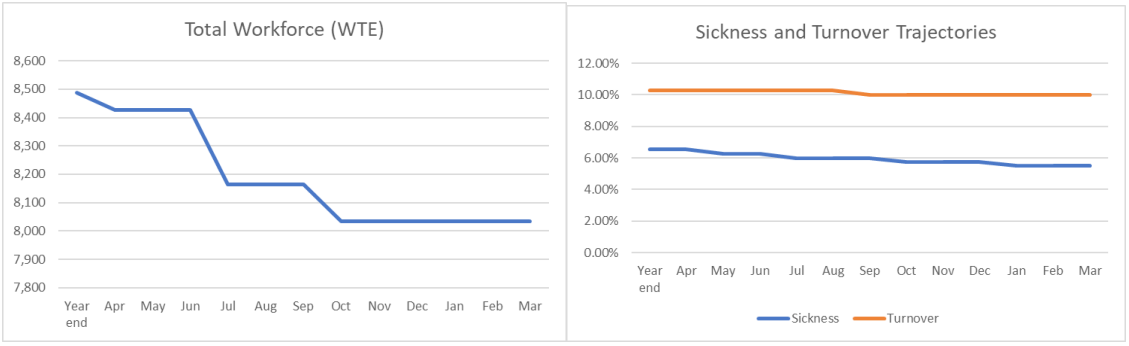
Alongside the financial plan, a workforce return is also required. This includes detail around projected establishments by staff group and by month as well as specific KPIs around sickness and turnover rates.

These trajectories are outlined below.

Table 7: Workforce Trajectories

Workforce Trajectories	Year end	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Workforce (WTE)	8,487	8,428	8,428	8,428	8,163	8,163	8,163	8,033	8,033	8,033	8,033	8,033	8,033
Total Substantive	8,017	7,957	7,957	7,957	7,895	7,895	7,895	7,846	7,846	7,846	7,846	7,846	7,846
Total Bank	285	285	285	285	157	157	157	105	105	105	105	105	105
Total Agency	186	186	186	186	111	111	111	82	82	82	82	82	82
Sickness	6.56%	6.56%	6.25%	6.25%	6.00%	6.00%	6.00%	5.75%	5.75%	5.75%	5.50%	5.50%	5.50%
Turnover	10.27%	10.27%	10.27%	10.27%	10.27%	10.27%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%

Chart 1: Workforce Trajectories



5. Activity Trajectories

The Trust are required to submit activity and performance trajectories across a range of measures. These are outlined below. The Trust submission forms only part of the contribution to the overall MHLDA section of the national activity and performance submission for the ICB that is submitted by the ICB to NHS England. The enclosed table 8 includes what was submitted by CNTW to the ICB. The ICB will collate this with other providers and then only the ICB total figures are submitted nationally. The only exception is Out of Area Placements (OAPs) which is at provider level. This is submitted by CNTW and TEWV to the ICB and the provider figures and the total ICB figure are then submitted to NHS England by the ICB.

Table 8: Planning activity trajectories

	Active inappropriate adult acute mental health out of areas placements (OAPs)														
	Provider		CNTW sto ICB level submission												
	Dec-23	Plan Basis	Apr 2024-Mar 2025 **Average**	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Active inappropriate adult acute mental health out of areas placements (OAPs)	0	end of period position	1.75	6	5	4	3	2	1	0	0	0	0	0	0

	Access to NHS talking therapies for anxiety and depression - reliable recovery														
	ICB		CNTW sto ICB level submission												
	Dec-23	Plan Basis	Apr 2024-Mar 2025	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of patients that achieved reliable recovery	1,145	in period activity	3060	255	255	255	255	255	255	255	255	255	255	255	255
Number of patients discharged having received at least 2 treatment appointments in the reporting period, that meet caseness at the start of treatment.	2,420	in period activity	5880	490	490	490	490	490	490	490	490	490	490	490	490
%	47	in period activity	52	52	52	52	52	52	52	52	52	52	52	52	52

	Access to NHS talking therapies for anxiety and depression - reliable improvement														
	ICB		CNTW sto ICB level submission												
	Dec-23	Plan Basis	Apr 2024-Mar 2025	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of patients that achieved reliable improvement	1,725	in period activity	5100	425	425	425	425	425	425	425	425	425	425	425	425
Number of people who are discharged having received at least 2 treatment appointments in the reporting period.	2,520	in period activity	7200	600	600	600	600	600	600	600	600	600	600	600	600
%	68	in period activity	71	71	71	71	71	71	71	71	71	71	71	71	71

	Estimated diagnosis rate for people with dementia														
	ICB		CNTW sto ICB level submission												
	Jan-24	Plan Basis	Apr 2024-Mar 2025 **Average**	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of people aged 65 or over diagnosed with dementia	27,544	end of period	16883.08	16,527	16,583	16,636	16,727	16784	16837	16928	16985	17037	17129	17186	17238
Estimated prevalence of dementia based on GP registered populations	40,315	end of period	24860	24,668	24,703	24,738	24,773	24808	24843	24877	24912	24947	24982	25017	25052
Estimated prevalence of dementia based on GP registered populations	68.32	end of period	67.91	67	67.13	67.25	67.52	67.66	67.77	68.05	68.18	68.29	68.57	68.7	68.81

	People with severe mental illness receiving a full annual physical health check and follow up interventions														
	ICB		CNTW sto ICB level submission												
	Sep-23	Plan Basis	Apr 2024-Mar 2025 **Average**	Quarter 1 2024/25	Quarter 2 2024/25	Quarter 3 2024/25	Quarter 4 2024/25								
People with severe mental illness receiving a full annual physical health check and follow up interventions	13,808	12-month rolling	212.5	212	212	213	213								
Number of people on the General Practice SMI registers'	23,960	12-month rolling													
Percentage of people with severe mental illness receiving a full annual physical health check	57.63	12-month rolling													

	Overall Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses														
	ICB														
	Dec-23	Plan Basis	Apr 2024-Mar 2025 **Average**	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Overall Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	5,190	12-month rolling		ICB are submitting this											

	People Accessing Specialist Community Perinatal Mental Health Services														
	ICB		CNTW sto ICB level submission												
	Dec-23	Plan Basis	Apr 2024-Mar 2025 **Average**	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of people accessing specialist community PMH and MMHS services in the reporting period	2,335	12-month rolling	1557.08	1,503	1,513	1,522	1,532	1542	1552	1562	1572	1581	1591	1601	1614

	Access to Children and Young People Mental Health Services														
	ICB		CNTW sto ICB level submission												
	Dec-23	Plan Basis	Apr 2024-Mar 2025 **Average**	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	57,205	12-month rolling	20124.67	19,773	19,836	19,899	19,962	20025	20089	20155	20220	20286	20352	20415	20484

6. Annual Plan Priorities

The finalised Annual Priorities are included in Appendix 1, these were approved by the Board of Directors on 2nd May 2024.

7. Recommendation

The Board of Directors are asked to note the latest position on planning highlighted in this report.

8. Appendices

Appendix 1: Trust Annual Priorities 2024/25

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

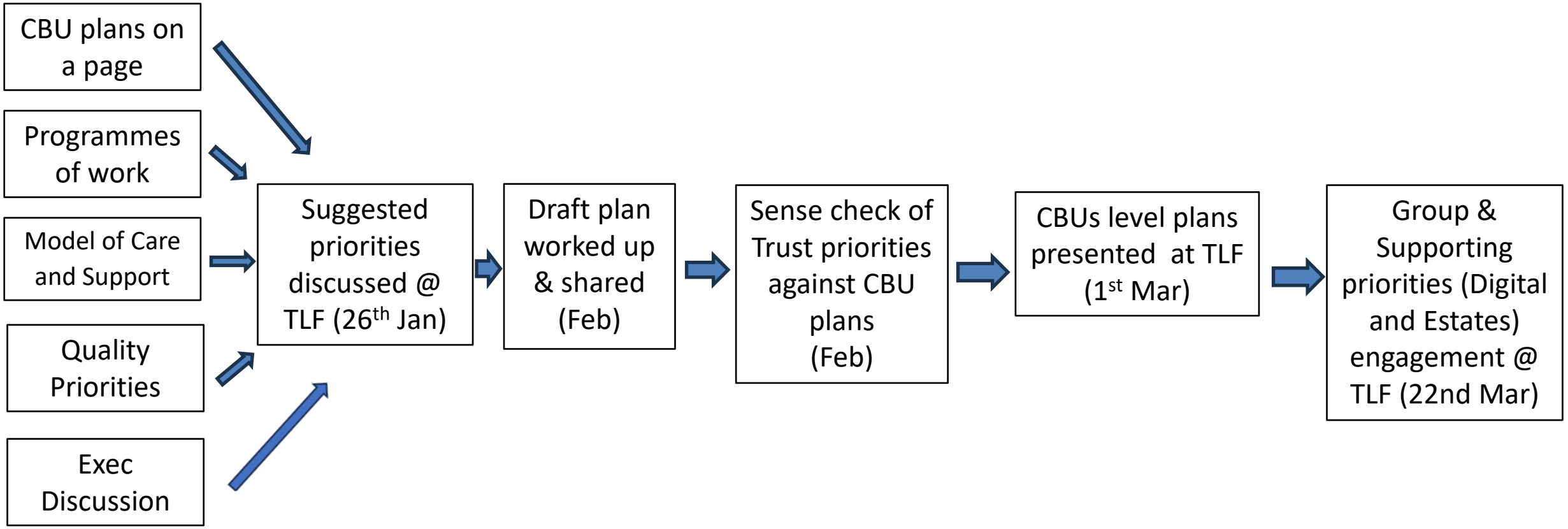
2024/25 Trust Priorities

Trust Leadership Forum

22nd March 2024

With YOU in mind

Trust Planning | TLF Engagement



Ambition 1 | Quality of Care Every Day

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurables
Implement PSIRF (Patient Safety Incident Response Framework)	• PSIRF implemented - assured via submissions to the ICB Q&P reports • Measure of psychological safety of staff following incidents • Staff survey
Delivering on the key learning from key safety improvement themes; • Reduce violence • Improve Physical Healthcare • Reduction in Suicides • Reduce restrictive practice	• Reduction in Serious Incidents and Harm Incidents – particularly in themes of violence • Patient related measure in relation to physical health - TBD • Reducing incidents of self harm and suicide • Reducing levels of long term segregation and prolonged seclusion, and restraint
Ensure that the six principles of the Triangle of Care are fully embedded throughout the organisation.	• Improve the performance of the six standards of the Triangle of Standards.
Embed learning through research and informing improvements in care delivery	• Increase staff participation in learning and research
Embed a culture of Trauma Informed Care and its approaches across the organisation	• Delivery of Trauma Informed Care Training plan, moving on to improved 'Your Voice' results following implementation

Ambition 2 | Person Led Care

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Implement Inpatient Quality Transformation with purposeful admissions, therapeutic care and effective discharges	Zero Out of Area placements, reduce delayed discharges, reduce lengths of stay, and reduced bed occupancy
Develop new models of care and support for those in crisis	Crisis – Very urgent seen within 4 hours and urgent within 24 hours Psychiatric Liaison Assessment – 1hr ED and 24hr acute ward response
Move away from CPA to a new model of care and support	Improvements in the timeliness of the 4 week wait standard
Set up new Wellbeing Hubs at a local level and improve integration with primary care	Increase the number of physical well-being partnership hubs with and without walk-in access
Increase access to evidence-based treatment including review of Specialist Psychological Therapy Services	• Delivery training on evidenced based competencies to staff • Complete and implement review of Specialist Psychological Therapy Services
Redesign and implement a radically different pathway for neurodevelopment needs	Improve waits to be seen, assessed and treated for patients of all ages with Neurodevelopmental needs
Develop with partners an integrated approach to support children and their families	Improve waits to be seen, assessed and treated for patients of all ages with Neurodevelopmental needs

Ambition 2 | Person Led Care

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Transitions – develop effective pathways for CYPS transitions into Adults	Effective transitions pathways implemented
Implement Transforming Care ways of working	Improve the quality of care, enhance community capacity and reduce inappropriate admissions for patients with a learning disability and or autism Deliver against Transforming Care Programme
Identify and address areas at risk of closed cultures – Northgate Cultural Review	Develop and implement a plan for identifying and addressing areas with a closed culture including increased visibility and peer review
Ensure pathways for all localities have a clear and standardised offer for Alcohol and Drug presentations, including appropriate scaffolding and advice.	Pathways for alcohol and drug presentations are clearly defined, standardised and implemented.
ICB review of Neurorehabilitation services including; inpatient, community and specialist placements	Work effectively with the ICB on the review of Neurorehabilitation services
Integrate specialist psychological services with community services	Successful implementation of integrated pathways for patients
Review and improve waiting times in Gender Services – secure funding and transfer responsibility for surgical pathway	Gender Service waiting times improved

Ambition 3 | A Great Place to Work

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Refresh development offer for teams/individuals and agree a delivery plan for the next 1 -3 years. Priorities for 2024/25: • Leadership programme to support new operating model • Roll out healthcare support workers development programme • Introduce comprehensive induction programme for unregistered staff • Introduce Edward Jenner programme for new starters into the Trust if no leadership qualifications held	Numbers of staff attending programmes Increased numbers of unregistered staff progressing within the Trust Increased retention for these staff groups Staff Survey and People Pulse metrics including questions relating to: - leadership/management - development opportunities - career progression - job satisfaction - motivation - engagement
Refresh Freedom to Speak Up approach including development of champion roles	Staff Survey responses relating to Speaking Up
Improve Employee Relations processes supported by just culture principles and implement a Resolution policy	Reduction in: - numbers of formal cases - grievances - timescales for all cases - Suspensions and non-clinical duties

Ambition 3 | A Great Place to Work

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Put in measures to address key Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators: • Reduce discrimination, bullying and harassment • Improve progression for BAME Staff	• Improvements in relevant WRES/WDES indicators • Improvements in Staff Survey and People Pulse metrics relating to discrimination, bullying and harassment • Increased number of BAME staff gaining promotion into more senior roles
Develop a sustainable Trustwide workforce plan	Workforce plan in place Reduction in agency usage
Support the wellbeing of staff by: • Improve the uptake of wellbeing conversations • Review appraisal process in line with you in mind ensuring staff have clarity around roles, responsibilities and objectives • Continue to roll out the management skills programme • Develop Coaching/Mentoring offer for staff	Increase in staff who have had a wellbeing conversation Improved Staff Survey metrics relating to: - staff having an appraisal - quality of appraisal - clarity of roles and responsibilities
Ensure we recognise the importance of veterans across a range of commitments to our workforce, in our service delivery and across our partnerships	Development and delivery of a 'Veterans plan'

Ambition 4 | Sustainable for the long term

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Achieve financial balance in 24/25	Financial position reported to ICB and Board of Directors
Shift the Trust planning horizon to focus on medium term sustainability	Agree 3 year financial improvement trajectories for each service to deliver a sustainable £5m annual surplus
Delivery of Key Digital projects • Development of the shared care record • Implement Manager Self Service ESR • Roll out Allocate across Inpatient Areas • Develop business case for Patient Engagement Portal • Continue to support NENC SDE (funding host) (attracting R&D funding as an ICS)	Successful delivery of projects. Monitored via DPSG and RABAC.
Delivery of Key Estates projects • CEDAR (Ferndene and Bamburgh) • CAV OPS move • Benton House • Hadrian Phase 3 • Acorn s136 and crisis hub • Tweed courtyards Consider how Trauma informed approaches can be incorporated into our process to inform the design of our environments.	Successful delivery of projects. Assurances via RABAC

Ambition 5 | Partnerships

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Develop a VCSE approach embedded in place	Record of the number of VCSE organisations working with the localities and Trust in delivering CMH Transformation and other Trust priorities (including narrative on the 'what')
Influence the new structure to ensure we have no internal barriers to providing seamless care to patients.	Feedback through monitoring of transition issues between community, inpatient and specialist services through incidents and complaints. Feedback from service users and carers
Agree a way of working with the ICB at system level which supports a transformative approach which delivers significant improvement for the population and communities of the North East and North Cumbria.	Agreement of framework in place with the ICB.
Work effectively with the Great Northern Alliance at place level to ensure parity of esteem for Mental Health.	Agreed Framework to be discussed at Board
Improve integration of clinical pathways with our partners in TEWV NHS FT	Agreement of a framework & principles to improve integration within the Provider Collaborative.
Developing a health inequalities plan focusing on reducing inequity,	Delivering on the key milestones agreed through the Inequalities

Trust Planning | Next Steps

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

- Quarterly monitoring of Annual Plan via IPR+
- EMG & Board Ratification – April Board of Directors
- Issue template for Group plans – end of March (Plan on a page)
- Group plans to be submitted by end of April (Tommy)
- Progress against group plans discussed at Quarterly Well Led meetings
- At the end of the session we'll check whether TLF feel sufficiently engaged to inform next years approach….

5.3 INTEGRATED PERFORMANCE REPORT ? SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERY DAY

Kevin Scollay, Executive Director of Finance

For Assurance

5.4 RESOURCE AND BUSINESS ASSURANCE COMMITTEE REPORT

Paula Breen, Committee Chair

For Assurance

REFERENCES

Only PDFs are attached

5.4 RABAC Committee Assurance Report - Mar 24.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Wednesday 5 June 2024

Name of Board Committee	**Resources and Business Assurance Committee**
Date of Committee meeting held	3 May 2024
Date of next Committee meeting	7 August 2024

1. Key areas of Focus

- 23/24 Financial Position Report – **discussion and assurance**
- 24/24 Financial Planning – **discussion**
- CEDAR update – **discussion and assurance**
- Annual Cost Collection – **approval of process**
- Specialist Mental Health Provider Collaborative update (incl. update on Birch Ward) – **assurance**
- Lead provider update – **assurance**
- Digital projects update – **assurance**
- Digital – Cyber and DSPT Update – **discussion and assurance**
- BAF and Risk exception report – **assurance**
- Information items (sub-group minutes) – **information only**

2. Current risks and gaps in assurance, and barriers to closing the gaps

During the meeting, the Committee noted and discussed the following issues in terms of current risks and gaps in assurance.

<u>24/25 Year End</u>
The committee received the Finance report relating to Month 12. The committee heard that although the Trust will report an £85m deficit, from a financial performance perspective the Trust has reported a small favourable variance of £58k. The transactions which generate the significant deficit were explained and relate predominantly to changes in accounting rules for PFI contracts, lease revaluations and impairments relating to assets which have now been fully recognised, such as the Sycamore estates development.

The committee heard the continued positive news on reductions in agency staff costs, which has ended the year below plan and is now consistently below the agency ceiling, which is positive from a regulatory perspective.

The committee heard that the Trust performed in line with ICB expectations around its capital limit (CDEL).

<u>Medium Term Financial Planning</u>
The committee received an update on the 24/25 financial plan, which was discussed and approved at an Extraordinary Board on 2nd May 2024. The committee heard about the key risks inherent in this plan. In essence these are:

- A deficit plan is unsustainable as it depletes financial resources as not adhering to NHS business planning rules.
- Planning risk exists within the current Income and Expenditure plan - £6.2m of savings are currently unidentified. The committee were advised that ideas for further savings are currently being explored.
- Delivery risk exists on existing plans – specifically risk associated with containing costs with ward budgets and corporate savings were flagged as having some risk on delivery
- Capital (CDEL) limits – the committee were advised that approval of the CAV business case creates a significant pressure on the capital envelope and the financial plan assumes slippage. There are a number of other estates developments that may create additional expenditure on the capita programme. Breaking the CDEL envelope is judged as being a high risk.
- Cash – cash reserves are expected to be significantly depleted through 24/25 as a result of how the financial plan is configured (deficit plan, high levels of non-cash items supporting I&E) and there is risk of further reductions if capital expenditure is higher than expected, which is likely based on the current commitments and other risks included in the capital plan.

CEDAR
The Committee noted the verbal update on the CEDAR project. This project has been an area of concern as Treasury approval to proceed with the plan had not been received, but now has. The committee heard an update on the current position with the land sale.

Annual Cost Collection
The committee received an update on the proposed process for the annual cost collection (previously known as reference costs). The process was approved by the committee and authorisation was delegated to the Director of Finance to approve the submission once ready. A further update on this issue is planned for August.

Digital
The committee received assurances around the delivery of digital projects. It also received an update on cyber security arrangements and the DSPT.

Commissioning
The committee heard updates on the provider collaborative and lead provider arrangements. Reporting around provider collaborative arrangements have been developed further this month. An update was received around Birch Ward (adult eating disorders) and the actions being taken to enable this ward to reopen safely.

3. Key challenges now and in the medium term

The key challenge faced by the Trust is the development of a compliant (i.e. breakeven) 24/25 financial plan, alongside the development of a medium-term sustainability plan.

Immediate challenges were reported in relation reopening Birch Ward (an adult eating disorder ward which closed to new admissions earlier this year). At time of writing, this ward was has been reopened with a phased reopening plan.

4. Impact actions taken to date are having on the achievement of our strategic ambitions

Key actions taken:

- Increased focus on delivery plans for identified – particularly in relation to at risk areas such as corporate and containing costs within ward budgets.
- Ongoing discussions are taking place with NHSE Specialised Commissioners to secure bridging income to mitigate the loss of specialist income in relation to the closure of Lennox ward.
- Birch ward (commissioned by the Trust within the Provider Collaborative) entered enhanced monitoring on quality and safety grounds. (This ward has subsequently successfully reopened with a phased plan)

5. Barriers to progress and impact on achievement of strategic ambitions

ICS Resources

The ICS, in-line with the wider NHS, is experiencing a tightening of financial resources available to invest in services and mitigate ongoing, significant underlying financial pressures. This impacts the Trust by constraining financial resources available to the Trust to continue to grow the size of the workforce. Delivery of the financial obligations of the Trust are therefore dependent on improving use of existing resources and containing expenditure within existing income envelopes. This means the Trust is required to repurpose existing resources to better effect to maintain quality and safety whilst remaining financially sustainable. This places significant emphasis on the ability of the Trust to transform its model of care in order to reduce overall costs of service deliver, which is the main focus of the current plan and strategy for the organisation.

6. Actions to be taken prior to next meeting of the Committee

The Committee were advised that focussed work is currently taking place around improving assurances around existing savings schemes. Specifically corporate and ward budgets.

An action plan has been developed around Birch Ward to ensure it is able to be reopened to new referrals safely. This has now taken place. Some elements of monitoring will remain at an enhanced level around this ward to ensure the improvements achieved to date are sustained and assurances received ongoingly in the short term that quality and safety standards are maintained.

7. Items recommended for escalation to the Board at a future meeting

The underlying financial position remains a continued area of emphasis, though no specific items are escalated at this point.

8. Summary of Approval, decisions and ratification of items taken the meeting

The Committee were asked to approve the plan relating to the annual cost collection and delegation of approval of the submission to the Director of Finance.

9. Review of Board Assurance Framework and amendments thereon

At the May meeting of the Resources and Business Assurance Committee, BAF risks associated with the delegated responsibility of the Committee were reviewed. The highest scoring BAF risk (scoring 16 and above) is as follows.

Resource and Business Assurance Committee		
BAF Risk 2545	**Residual Score 16**	
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		
• (No longer relevant as Groups will move to new structures and in year financial position is fully mitigated) • Absence of a medium/long-term financial plan. • Absence of medium financial recovery trajectories by service line • 24/25 plan is unsustainable (£3.9m deficit) and contains £6.2m of unidentified efficiencies		

The Committee noted the scoring attached to the risks and determined that risk 2545 is appropriately score. Given the scoring and the required focus strategically, a specific report is provided to the Board on the financial position.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.

Paul Breen
RABAC Chair
May 2024

Kevin Scollay
Executive Director of Finance

6. STRATEGIC AMBITION 5 ? WORKING FOR, AND WITH OUR COMMUNITIES

Darren Best, Chair

6.1 SYSTEM WORKING / POLICY UPDATE

James Duncan, Chief Executive

For Information

6.2 CHARITABLE FUNDS ASSURANCE COMMITTEE

Louise Nelson, Committee Chair

For Assurance

REFERENCES

Only PDFs are attached

6.2 Charitable Funds Committee Assurance Report June 2024.pdf

Board Committee Assurance Report
Meeting of the Board of Directors/Corporate Trustee (CLOSED)
Wednesday 5th June 2024

Name of Board Committee	**Charitable Funds Committee**
Date of Committee meeting held	1 May 2024
Agenda items/topics considered	See below
Date of next Committee meeting	31 July 2024

1. Key areas of focus

The meeting was chaired by Louise Nelson as Vikas Kumar who recently took over as Committee Chair dialled in from outside of the country.

A Charity Chairs Network has been recently formed by Newcastle Hospitals with the purpose to bring together Chairity Chairs across the North East and North Cumbria (NENC) to explore not only individual practices in the charities but to learn more about and from one another and to determine whether there was more to understand about the ICB in relation to our charities, fundraising and grant-making as well as exploring future working across the ICB. At the meeting it was suggested for Trusts to identify three needs and options to address health inequalities. The Charitable Funds Committee suggested, health inequalities for ethic groups, a focus on Learning Disability and Neurodiversity as well as exploring community spaces to be taken further at Board level to agree the three priority areas.

The Committee received an update on the expenditure log, and fund balances including the Trust's general 'Shine' Fund. Ten new funds were opened during period. Two applications were declined as the Committee decided that the purpose the application should not be funded through Charitable Funds and that the application could not be equitable across all Trust wards. Three Applications are awaiting further information and discussion.

2. Current risks and gaps in assurance and barriers to closing the gaps

2.1 Charity accounts update

The Committee received an update of the Charity accounts and financial position. Income from donations were comparable with the same period in the previous year. Charitable Activities expenditure shows much higher than the same period last year, this is primarily due to the agreement made in 2021 to donate £100k to the Trussell Trust and a corresponding increase in staffing charge, which is offset by the grants funding, received for the Marketing Officer Post. The net movement in fund balances is a decrease of just over £102k.

Cazenove's portfolio for indirect exposure to tobacco, alcohol and gambling has been received which remained under 1% of the portfolio and will be reported quarterly moving forward so the committee can remain updated.

2.2 Charity resource and support

It should be recognised that the Charity activity, awareness, and fundraising activities has increase significantly since summer 2023 following the move of the portfolio to the Communications Team directorate and investment in the Marketing Officer and Apprenticeship post. The Corporate Trustee (Board of Directors) are asked to note that the Marketing Officer is a temporary post, funded by NHSE up to the end of June 2024. The ability to sustain progress of charity activity will be greatly affected by the loss of this post and the Director of Communications and Corporate Affairs will be discussing this with the Committee Chair and Executive Director of Finance in the coming months.

3. Key challenges now and in the medium term

3.1 Positioning of NHS mental health and disability charities

The key challenge for the Trust Charity remains around our ability to compete with NHS Acute charities and increase the focus on the benefits of our charity on the wellbeing of people with mental health and disability issues. Whilst retaining its original name, the new SHINE brand now provides reference to its connection with the NHS and supporting NHS care.

3.2 Payment to NHS Charities

The Trust received a letter from NHS England to Chief Finance Officers of NHS Providers regarding payments to NHS Charities. The letter states that there have been some instances of Trusts moving money to their Charity, presumably with the intention of avoiding CDEL rules for creating buildings etc. The letter adds that payments from a Trust to their Charity would not be approved by the Treasury. The group confirmed that this would not impact any Trust raising funds for their charity but were asked to note the content of the letter.

4. Impact of actions taken to date on the achievement of our strategic ambitions

4.1 Impact of the charity of patient care and wellbeing

In line with the improved governance arrangements, the Committee continues to meet monthly to review and approve bids for fund use. 17 applications to withdraw from specific funds and 10 applications to withdraw from the Shine Fund. The impact of the funds on patient care, support for carers and staff continues to be shared in line with the Charity Annual Plan and Strategy. The improved communications and engagement to support the charity outlines the positive impact initiatives can have on the wellbeing of those who use our services, as well as our workforce.

A key aim of our marketing approach has been to refresh and relaunch the charity brand promoting the value, support and impact of donors, volunteers, and supporters. This includes encouraging and increasing fundraising efforts and raise the profile of mental health and learning disabilities and help tackle the stigma often associated. The Committee was provided with examples of the new integrated marketing approach has used to develop a wide range of print and digital assets to inform, educate and encourage support and fundraising efforts.

Our approach during the period has resulted in the use of video's, radio promotion and interviews with those who have been impacted positively by charitable donations and

strengthening of online content including use if imagery, stories, and functionality of the intranet and website.

Following the success of the last seven months we plan to increase the number of fundraising activities throughout 2024 and beyond. We have seen a large increase in donations via fundraising events already and we are confident this will continue. We are exploring new opportunities working with external organisations i.e., through corporate giving schemes and relationships with external corporate organisations Starbucks, Newcastle United Foundation, Foundation of Light, Barbour and others. We are also hoping to secure a patron for the Charity over the coming months.

There has been the launch of the new Shine signage on St Nicholas Hospital site and is planned to be rolled out across all sites in the coming months. These signs are colourful and have a QR code enabling easy access for further information or to donate.

4.2 Example of the impact the charity can have…

The Committee received an update on the launch of the Cycle Hub at St Georges Park which has gained lots of engagement through social media promotion and the Committee will receive an update from St Georges in the coming months. Stagecoach in Cumbria have been promoting Shine at Carlilse and Workington bus stations on over 100 posters on buses and via communications on their Twitter account which has over 8,000 followers. Bellway have recently donated £500 to Shine. There have been several Great North Run fundraisers launched and supported as well as a Volunteer Fundraising Committee being launched soon and supporting a number of upcoming fundraisers such as EIP team's voyage, Hadrian's Wall Walk and Hopewood Parks 10-year anniversary.

5. Barriers to progress and impact on achievement of strategic ambitions

See section 2.2 above.

6. Actions to be taken prior to next meeting of the Committee

- Continuous review the charity investment portfolio.
- Update from the Chair following the NHS Charity Chairs meeting and review any learning and opportunities for joint working.
- Discuss future resource support for the Charity.

7. Items recommended for escalation to the Board at a future meeting

There are no items for escalation to the Board at this stage and the Committee feels it has an appropriate level of assurance in terms of management of the Charity on behalf of the Corporate Trustee (Board of Directors).

8. Summary of Approval, decisions and ratification of items taken the meeting

The Committee continues to review and approve individual bids from services in line with the delegated authority outlined in its terms of reference.

9. Review of Board Assurance Framework and amendments thereon

There are no BAF risks associated with the Charitable Funds Committee.

10. Recommendations

The Board is asked to note the content of the report and seek further assurance from the Committee Chair and Executive Lead if required.

Louise Nelson **People Committee Chair** **March 2024**	Debbie Henderson **Director of Communications and Corporate Affairs**	Kevin Scollay **Executive Director of Finance**

7. GOVERNANCE AND REGULATORY

7.1 AUDIT COMMITTEE ASSURANCE REPORT

David Arthur, Committee Chair

For Assurance

REFERENCES

Only PDFs are attached

7.1 Audit Committee Assurancce Report - May (June Board) 24.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Held Wednesday 5 June 2024

Name of Board Committee	**Audit Committee**
Date of Committee meeting held	8 May 2024
Agenda items/topics considered	See Appendix A
Date of next Committee meeting	19 June 2024 – Annual Report and Accounts review

1. Chair's summary

The May meeting of the Audit Committee was a particularly busy meeting, which included 'business as usual' assurance items, as well as end of year submissions for review in line with the Trust's annual reporting process.

As well as items covered elsewhere in this report, the meeting received updates in relation to formal reports to support the development of the Trust Annual Accounts and governance statements to support the Trust Annual Report. The full agenda is detailed in Appendix 1. From an internal and external audit perspective, the Committee also reviewed the External Audit Strategy memorandum which summarised the audit approach for the year, highlighted audit risks and areas of key judgements as of 31 March 2024. Local Counter Fraud provided an update on work undertaken between January and April 2024 including an update on correspondence from NHSE regarding a recent judgement made by HM Treasury in respect of payments from NHS Trusts to their respective charities.

Key issues from the meeting are provided in the following sections.

2. Current risks and gaps in assurance, and barriers to closing the gaps

2.1 Limited assurance internal audit report on Duty of Candour

The Associate Director of Safer Care provided an update on the actions taken to address the audit recommendations within the report. The recommendations had been discussed in detail at the Trust wide Safety Group which included a review and update of the Being Open Policy Guidance Note (PGN) to ensure it aligns with national guidance and PSIRF recommendations, a review and update of the practice expectations to ensure that a clear process is in place, and a review of where information needs to be recorded. A collaborative piece of work has been undertaken with the Digital Team to design a new RiO form which will ensure that Duty of Candour will be recorded within a patient record moving forward. Sessions at managers meetings and other forums to raise the profile of Duty of Candour have also been implemented.

The Committee referred to the communications used in the Duty of Candour process, and it was noted that further work was required to ensure accessibility standards were met. Internal Audit confirmed that a clear and robust action plan was in place, and it was agreed that a follow up review will be included in the 2024-25 Internal Audit plan.

2.2 Limited assurance internal audit report on local induction (onboarding process)

Lynne Shaw, Executive Director of Workforce and Organisational Development provided an update on the actions taken in response to the recommendation made. These included strengthening messaging to managers across the organisation, increasing attendance at the

management skills programme which includes induction delivery, improvements in terms of ID checks on individuals on the first day of employment with the Trust, and undertake a review of Trust Induction policy. Again, a follow-up review will be included within the 2024-25 Internal Audit Programme.

3. Key challenges now and in the medium term

In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit, and other independent assurance functions, but will not be limited to these audit functions. The Committee will seek reports and assurance from Directors and managers as appropriate, based on the key risks and issues facing the organisation in the context of integrated governance, risk management and internal control. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee received the update on the draft accounts and significant transactions in relation to 2023/24. This included updates on financial performance and the NHS financial framework, impairments (relating to both owned and leased property), and IFRS 16 liability measurement principles to PFI liabilities.

The key challenge remains the long term financial sustainability for both the Trust, NENC Integrated Care System and the NHS as a whole, particularly in terms of the lack of clarity currently at a national level in terms of long term planning.

4. Impact actions taken to date are having on the achievement of our strategic ambitions

4.1 PSIRF Update

The Committee noted the assurance provided in terms of the work undertaken to implement PSIRF, particularly in the context of the three safety priorities in relation to self-harm, violence and aggression and physical health. Training has been provided to 600 clinical staff to date and incident policies and practices have been updated to align with the PSIRF Policy and Plan. The update included an overview of processes associated with Early Learning Reports (ELR) and After-Action Reviews (AAR). The Committee were also advised of the expectation that approximately 10-12 Patient Safety Incident Investigations (PSII) will be undertaken per year. Clarification on the responsibilities of the Board for reviewing and signing off PSIIs will be provided to the August meeting.

4.2 EPRR / staff attack alarms

The Director of Health, Safety Resilience and Innovation provided an update on the Trust's compliance with EPRR Core Standards and staff attack personal alarms. Strong assurance was provided on the work undertaken during 2023-24 to fulfil the EPRR agenda and assurance around business continuity, although it was noted that compliance against the standards was at 62.5% however, the Committee were assured that plans were in place to address non-compliant actions by the end of quarter 2.

With regard to staff attack and personal alarms, an issue was previously identified following receipt of the Health and Safety Executive (HSE) Improvement Notice of a lack of ability for staff attack alarms to work in the grounds between the Mitford Unit and Bungalows. Assurance was provided that the issue had been resolved, with additional sensors being placed on the

site which enable the alarms to work. Additional information was provided on improvement work ongoing in relation to maintaining staff safety across the Trust.

4.3 Cyber-security risks
The Head of Informatics and Infrastructure provided an update in relation to cyber related assurance referring to several ongoing external assessments to provide additional assurance, as well as internal mitigations in place. It was noted that a recent back-up audit provided 'substantial' assurance with no recommendations which is testament to the focused work undertaken in this area.

4.4 Internal Audit progress update
The Internal Audit report provided detail on twelve final reports issued during the period. Delivery of the plan remains on track. The core assurance audits remain on schedule to be completed in time for the Head of Internal Audit Opinion.

Audit involvement has continued with the Patient Safety Incident Response Framework (PSIRF) implementation, with a number of observations including, improving PSIRF Oversight Group meeting attendance, ensuring meetings are minuted, and ensuring expectations are clear for group leads that action plan dates must deliver timely outputs to the Group.

Overall, the Internal Audit programme continues to be aligned to the Trust's Board Assurance Framework and key areas of risk and focus for the organisation.

4.5 Draft Head of Internal Audit Opinion
Internal Audit presented the draft Internal Audit Plan for 2024/25 and reported that the draft Head of Internal Audit Opinion provides good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls are generally being applied consistently.

5. Barriers to progress and impact on achievement of strategic ambitions
See section 3 and section 8.

6. Actions to be taken prior to next meeting of the Committee

- Ensure accessibility issues relating to Duty of Candour are being addressed/actioned.
- Continue in discussions with regional Audit Committee Chairs regarding risk management processes / policies and BAF development.
- Take steps to improvement the position regarding management responses to internal audit recommendations.
- Clarification on the responsibilities of the Board for reviewing and signing off PSIIs will be provided to the August meeting

7. Items recommended for escalation to the Board at a future meeting
Key items which were discussed in detail for the Board's awareness related to governance reports and reviews in line with the Trust's annual reporting process:

7.1 CQC notification
The Executive Director of Nursing, Therapies and Quality Assurance reported that notification was received from the CQC of their intention to undertake further investigation via the National team, following an incident in 2022. This item will be discussed at the June Board meeting.

7.2 Audit Committee annual effectiveness and terms of reference review
The annual effectiveness review was undertaken in line with the guidance from the NHS Audit Committee handbook. Eight members of the committee completed the review, and strong assurance was provided on its performance throughout the year. There were no significant issues to note. The terms of reference have been reviewed and are included for approval in the June Board papers.

7.3 Audit Committee Annual Report 2023/24
This outlines the business of the Committee for the year and will be included in the Trust Annual Report 2023/24 at the Extraordinary Board meeting to be held in June.

7.4 Draft Annual Governance Statement 2023/24
The Committee received the draft Annual Governance Statement, a statutory statement which explains the processes and procedures in place to enable the Trust to operate effectively including, systems of internal control, governance, risk and effective use of resources. The final AGS will be included in the Trust's Annual Report 2023/24.

7.5 Trust compliance against the requirements of the NHS Code of Governance
The Committee received the report on compliance with the Code, noting that the Trust remains compliant for all requirements, except the following:

Section B 2.5 and Section D 2.1 – the requirement that the Trust appointed Senior Independent Director (SID) is not also the Chair of the Audit Committee. It was noted that David Arthur holds the role of both SID and Chair of the Audit Committee.

It has been determined that no conflicts exist in this regard and the Board are asked to support an explain approach to this requirement and the recommendation that David continues in these roles. David will be stepping down from his role in January 2025 at which point, the role of SID will be reviewed.

7.6 Proposed amendments to the Standing Financial Instructions
The Audit Committee supported the proposed amendments which are included on the June Board for approval.

7.7 Proposed collaboration on risk management
David Arthur referred to discussions with Audit Chair colleagues across the region, and proposals around an opportunity to share learning in terms of risk management processes and the development, and use of Board Assurance Frameworks.

7.8 Management responses to Internal Audit Recommendations
David Arthur asked that concerns regarding the management delays in responding to Internal Audit recommendations be escalated to the Board to request support from the Executive Team to ensure timely responses in future.

8. Review of Board Assurance Framework/Corporate Risk Register
Louise Nelson attended the meeting as Chair of the Quality and Performance Committee and provided a strong level of assurance that the Committee continues to monitor, review and discuss risks associated with its remit and delegated authority from the Board.

BAF risks associated with the delegated responsibility of the Committee were reviewed. The highest scoring BAF risk (scoring 16 and above) were as follows.

Quality and Performance Committee		
BAF Risk 2510	**Residual Score 16**	
Due to increased demand the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		
Gaps in Controls/Assurances include: • Demand for key pathways significantly exceeding capacity and requiring radical redesign. • Ability to recruit and develop skills to provide quicker access to evidence based treatments. • Keeping In Touch process for service users on assessment waiting lists which the numbers are significantly high. • Fully implement 4 week waits. • Embed the Trusted Assessment concept into community services. • Increased external demand on crisis services, specifically Right Care Right Person and NHS 111. • Crisis and alternatives to admission. • Lack of specialist provision for some patient groups. • Limited availability of seven-day week service provision from both an inpatient and community perspective. • Lack of intermediate care opportunities.		
Resource and Business Assurance Committee		
BAF Risk 2545	**Residual Score 16**	
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		
• (No longer relevant as Groups will move to new structures and in year financial position is fully mitigated) • Absence of a medium/long-term financial plan. • Absence of medium financial recovery trajectories by service line • 24/25 plan is unsustainable (£3.9m deficit) and contains £6.2m of unidentified efficiencies.		
People Committee		
BAF Risk 2542	**Residual Score 16**	
Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		

• Absence of a sustainable workforce plan. • Establishment control to ensure accurate recording and reporting of vacancies. • Current workforce skills are not currently recorded and mapped against post requirements. • Skills gaps are not identified, and adequate training put in place to address the shortfalls. • Inclusive recruitment work has had an impact on increasing the BAME workforce but predominantly this is in lower banded posts. • Strengthening of internal process for accessing development monies required. • Release of staff to undertake relevant training and development opportunities is currently a challenge. • Lack of joined up approach between appraisals and training requirements. • Challenges ensuring the temporary workforce maintain the required skills. • More robust recording and reporting mechanisms is required to enable leadership and management development and succession planning.

A discussion took place at People Committee, Quality and Performance Committee, and Resource and Business Assurance Committee regarding the ongoing appropriateness of the risks, risk descriptors, mitigations, and actions.

It was recognised that the new Board Assurance Framework was providing an important vehicle for Committees to sense-check and seek assurance that agendas, planning, discussions, and areas of focus were relevant and linked to the key issues facing the Trust.

It was agreed that a review of the risks and descriptors be undertaken during Q1 for each of the BAF risks with this learning in mind to ensure the value of the BAF in terms of informing focus remains in place, and indeed improves over time.

Corporate Risk Register (16+ high level risks)

The Committee also reviewed the Corporate Risk Register risks – the risks scoring 16+ with Executive/Director oversight. The risks, where appropriate, were aligned to relevant BAF risks supporting additional assurance in terms of the management of risks associated with the BAF.

The Committees noted that at the Trust's Executive Management Group meeting held 22 April, a discussion and sense-check took place on the Corporate Risk Register and what was perceived as the highest-level risks in the organisation (excluding the Board Assurance Framework risks). It was noted that there were potential gaps in relation to the following:

- Waiting times
- Access to Crisis Services
- Financial planning and delivery

It is proposed that these risks be considered during the next quarter with any additions to the Corporate Risk Register being reflected in the quarter 1 2024/25 report.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.
- **Support the recommendation** in section 7.5 to take an 'explain' approach to the requirements B 2.5 and D 2.1 of the NHS Code of Governance, which recommends that the Senior Independent Director should not undertake the role of Audit Committee Chair

David Arthur
Audit Committee Chair
Date: 23 May 2024

Appendix A – Audit Committee key agenda items
31 January 2024

- Chairs business
- Update on Patient Safety Incident Response Framework (PSIRF)
- Emergency Preparedness, Resilience and Response (EPRR) including Staff Attack Alarms update
- Update on Cyber Security / Risks
- Quality and Performance Committee review of risk management processes
- Audit Committee self-assessment outcome and Terms of Reference review
- Audit Committee Terms of Reference review
- CQC Visits and NHS Improvement Issues – by exception only
- Board Assurance Framework and Corporate Risk Register Q4 2023/24
- CNTW Audit Strategy Memorandum 2023/24
- Internal Audit Progress Report
- CNTW Group – suggested 2024/25 Internal Audit Plan 2024/25 including Draft Head of Internal Audit Opinion
- Limited Assurance Internal Audit Report on Duty of Candour
- Limited Assurance Internal Audit Report on Local Induction (Onboarding) Process
- CNTW Group Counter Fraud Progress Report January – March 2024
- Payments to NHS Charities – for information
- Significant Transactions 23/24 including Draft Group Annual Accounts 23/24
- Accounting Standards and Accounting Policies
- Finance AC Paper Group Losses and Special Payments
- Going Concern Report
- Group Waivers Report
- TCWG Responses Trust and NTWS
- Draft Annual Governance Statement
- Draft Audit Committee Annual Report 2023/24
- Compliance against the NHS Code of Governance
- Third Parties Annual Report
- Proposed Amendments to Standing Financial Instructions

7.2 FIT AND PROPER PERSONS / DECLARATION OF INTEREST ANNUAL REVIEW

Lynne Shaw, Executive Director of Workforce and OD

For Approval

REFERENCES

Only PDFs are attached

7.2a FPPT Update Final DH.pdf

7.2b Register of Interest Appendix 1.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 5th June 2024**
Title of report	**Fit and Proper Person Annual Assurance Report 2023/24**
Lead	**Debbie Henderson, Director of Communications and Corporate Affairs/ Trust Secretary**
Report author	**Kirsty Allan, Corporate Governance Manager/Deputy Trust Secretary**

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	X
4. Sustainable for the long term, innovating every day	
5. Working with and for our communities	

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

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

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

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

Board of Directors Meeting
Wednesday 5th June 2024

Fit and Proper Persons Annual Assurance 2023/24

1. Executive Summary

The purpose of this report is to provide annual assurance that all Board Directors, and those individuals employed for the Trust who fit the criteria of the Fit and Proper Person's national guidance, remain fit and proper for their roles.

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board Directors meet the 'Fit and Proper Persons Test.

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations in the Kark Review, NHS England developed a FPPT Framework to strengthen/reinforce individual accountability and transparency for Board members, thereby enhancing the quality of leadership within the NHS. This FPPT framework came into effect from 30 September 2023.

The Framework applies to the Board members of NHS organisations, irrespective of voting rights or contractual terms i.e., including the Director of Communications and Corporate Affairs/Company Secretary. Deputies are also included within the scope of the FPPT Framework.

Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

a) is not of good character.
b) does not have the necessary qualifications, competence, skills, and experience.
c) is not physically and mentally fit (after adjustments) to perform their duties.

These requirements play a major part in ensuring the accountability of leaders in NHS organisations and outline the requirements for robust recruitment and employment, appraisal, and performance management processes for Board level appointments and for ensuring that there are appropriate checks that leaders have the skills, knowledge and experience and integrity that they need – both when they are appointed and on an ongoing basis.

Fit and Proper Person: New Appointment and Annual Assurance Checks

All new Board appointments are subject to a full Fit and Proper Person Test that includes:

- Standard employment checks as per the Trusts Recruitment and Selection Procedure and NHS Employers Check Standards.
- Additional checks are undertaken by the Director of Communications and Corporate Affairs or deputy upon appointment / employment.

In April 2024, the Board of Directors completed the Fit and Proper Persons Test Self Declaration Form and additional checks as noted below in line with the new requirements of the FPPT Framework.

The Director of Communications and Corporate Affairs reviewed all declarations and determined that the Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

In addition, during the year 2023/24, the Executive Director of Workforce and OD has overseen the completion of pre-employment checks for new appointments and confirms that all checks meet the FPPT Framework.

Outcome of the Annual Fit and Proper Persons Checks

For annual assurance in April 2024, the Board of Directors completed the Fit and Proper Persons Self Declaration Form. For annual assurance FPPT checks also included:

- A search of insolvency and bankruptcy register.
- Search of Companies House register to ensure that no board member is disqualified as a director.
- Search of the Charity's Commission's Register or Removed Trustees,
- Web/Social Medial Search (new requirement).

Additionally, DBS checks are required to be conducted at least every three years and where practicable, these checks will be aligned to the annual self-declaration.

The outcome of the FPPTs have been saved on each personal file centrally held within the Corporate Affairs Office and uploaded onto ESR. They are then used to help inform discussions at formal appraisal processes.

Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attending of the Director of Communications and Corporate Affairs or the Trust Chair via the annual appraisal process.

Declaration of Interest

The NHS Code of Governance requires Board Directors to declare their interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties, and which could cause conflict between their private interests and their NHS duties and includes gifts and hospitality. Interests fall into the following categories:

- **Financial Interests:** Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- **Non-Financial Professional Interest:** Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved

in making such as, increasing their professional reputation or promoting their professional career.

- **Non-Financial Personal Interests**: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect Interests:** Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

Declaration of Interests was also conducted for each Board member during April which is outlined in Appendix 1 and will be published on the Trust website.

Recommendations

The Board is asked to:

- Note the content of this paper and receive assurance on compliance with the Fit of Proper Persons Test for NHS Providers.
- Record that the Fit and Proper Persons Test including Declaration of Interest has been conducted for the period 2023/24 and that all Board members satisfy the requirements.

Debbie Henderson
Director of Communications and Corporate Affairs / Trust Secretary

Kirsty Allan
Corporate Governance Manager / Deputy Trust Secretary

May 2024

Board of Directors Register of Interests: as at 12 April 2024

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register of Interests which draws together Declarations of Interest made by members of the Board of Directors. In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests on items on the agenda.

Name	Job Title	Nothing to Declare	Interests Declared
Darren Best	Chair		• Wife is a Headteacher of a Primary School om Teesside, within that role she has contact with the NHS, mainly in the context of safeguarding related matters. • Currently the Independent Chair for Teesside Safeguarding Adults Board (TSAB) with the contact/employment with end with TSAB on 18th April 2024.
Brendan Hill	Non-Executive Director (Vice Chair)		• Trustee on the Board of North East charity Ways to Wellness. Ways to Wellness has specialised in link work and social prescribing. It now works with health and care organisations (Statutory and VCS) in developing health and wellbeing test and learn projects, supporting prototypes, both local and at scale from the development of an idea through to delivery and evaluation. • Commenced role as Vice Chair for CNTW 1st October 2023
David Arthur	Non-Executive Director (Senior Independent Director)		• Chair of Governors at Dame Allan's School • Commenced role as Senior Independent Director for CNTW 1st July 2021
Michael Robinson	Non-Executive Director		• Member of the Labour Party

Name	Job Title	Nothing to Declare	Interests Declared
Louise Nelson	Non-Executive Director		• Chair of Carlisle Eden Mind
Paula Breen	Non-Executive Director		• Managing Partner Temple Sowerby Medical Practice, North Cumbria – Primary Care Provider in CNTW operating area • Strategic Practice Manager Alnwick Medical Group, Northumberland – Primary Care Provider in CNTW operating area • As Managing Partner of Temple Sowerby has a Profit Share interest of more than 5% • Daughter is a Registered Nurse Associate employed in North Cumbria and undertaking Locum work in Northumberland, Primary Care.
Vikas Kuma	Non-Executive Director		• CEO/Director, GemArts - deliver arts, health and wellbeing programmes in collaboration with NHS • Wife is Portfolio Lead Commissioning and Contracting, NENC ICB
Rachael Bourne	Non-Executive Director	✓	
Name	**Job Title**		**Interests Declared**

James Duncan	Chief Executive		• Member of the Labour Party • Son employed by NTW Solutions Limited commencing in role 2018. • Son employed by NTW Solutions Limited commencing in role April 2024.
Rajesh Nadkarni	Deputy Chief Executive / Medical Director		• Medical Director and Deputy Chief Executive, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. • Wife employed by Tees, Esk and Wear Valleys NHS Foundation Trust • Member of North East and North Cumbria Integrated Care Board • Invited member of NHS England Health and Justice Clinical Reference Group • Member of Advisory Forum on GMC Procedures and Doctors Health • Member of Mental Health Economics Collaborative Steering Group • Son employed by Cumbria Northumberland Tyne and Wear NHS Foundation Trust (bank work)
Ramona Duguid	Chief Operating Officer	✓	
Kevin Scollay	Executive Finance Director		• Partner is Head of Specialised commissioning finance at NHSE who commission CNTW for specialised services.
Sarah Rushbrooke	Executive Director of Nursing, Therapies and Quality Assurance	✓	
Lynne Shaw	Executive Director of Workforce and OD	✓	

7.3 MODERN SLAVERY STATEMENT

James Duncan, Chief Executive

For Approval

REFERENCES

Only PDFs are attached

7.3 Modern Slavery Statement June 24.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 5th June 2024**
Title of report	**Modern Slavery Statement 2023/24**
Lead	**Debbie Henderson, Director of Communications and Corporate Affairs/ Trust Secretary**
Report author	**Kirsty Allan, Corporate Governance Manager/Deputy Trust Secretary**

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	X
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 Management Group	
Audit			Business Delivery Group	
Mental Health Legislation			Trust Safety Group	
Remuneration Committee			Locality Operational Management Group	
Resource and Business Assurance				
Charitable Funds Committee				
Provider Collaborative/Lead Provider				
People				
CEDAR Programme Board				
Other/external (please specify)				

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

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

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Modern Slavery Statement June 2024

1. Introduction

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (the Trust or CNTW) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

There are many definitions of "modern slavery". Transparency International defines it as when an individual is exploited by others, for personal or commercial gain. Whether tricked, coerced or forced, they lose their freedom. This includes but is not limited to human trafficking, forced labour and debt bondage.

It involves the recruitment, movement, harbouring or receiving of children, women, or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of, or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude or even organ harvesting.

It is easy to think that modern slavery is a problem in other parts of the world and "doesn't happen here". But official figures suggest around 10,000 people in the UK are victims. Slavery experts believe the number is more like 100,000. In 2022, almost 17,000 potential victims of modern slavery were referred to the UKs National Referral Mechanism (NRM), representing a 33% increase on the previous year and the highest number of referrals since the NRM began in 2009.

The NHS procures a wide variety of goods and services, and some of the relevant sectors are certainly vulnerable to modern slavery. For example, there have been prosecutions in the UK in recent years relating to firms producing beds, garments, and food products – all major spend areas for many NHS Trusts.

The Trust has a zero-tolerance approach to any form of modern slavery or human trafficking. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguard against any form of modern slavery taking place within our business or supply chain.

2. About the Organisation

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest specialist providers of mental health and disability services within the UK. We employ nearly 9,000 staff and serve a local population of around 1.7 million people and have an annual turnover of around £600 million.

We work from over 70 sites across Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. We also provide a number of regional and national specialist services to England, Ireland, Scotland and Wales. Working across eight

Local Authorities and a partner member of North East and North Cumbria Integrated Care System.

3. Our Commitment

CNTW condemns slavery of all forms and is fully committed to working with suppliers within our supply chain to support the human rights and welfare of the employees working alongside CNTW. We expect organisations with whom we do business to adopt and enforce policies that comply with this legislation; and would immediately seek to terminate our relationship with a supplier where evidence of a failure to comply with our policies was discovered.

CNTW is committed to ensuring that those involved within the supply chain of our business operations are working of their own free volition, in the delivery of high-quality services to all customers through a skilled and experienced workforce. CNTW will endeavour to make a conscious effort to monitor operations to ensure no individual is taken advantage of. It is the intention of CNTW to train relevant staff to recognise and report instances where the freedom of an individual is questioned.

4. Arrangements to prevent slavery and human trafficking

The Trust is committed to ensuring there is no modern slavery or human trafficking in our organisation, our supply chains, or any part of our business activity. Our approach forms a key element of our wider commitment to social and environmental responsibility and modern slavery policy also forms part of our safeguarding strategy and arrangements.

Our approach includes internal policies to ensure that we are conducting business in an ethical and transparent manner. They include the following:

- **Recruitment**
  CNTW complies with external policies and processes for safe recruitment and where necessary relevant employment checks will be conducted. This includes conducting eligibility to work in the UK checks for all directly employed staff. External agencies are sourced through NHS nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.
- The approach for internal recruitment follows robust processes which are in line with UK Employment Laws including ‘right to work’ document checks and contracts of employment. Our Pay structure is from national collective agreements and is based on equal pay principles.

- **Trust policies and procedures**
  All policies and procedures are developed alongside the relevant subject matter expert and signed off at an appropriate level within the Organisation.

- **Safeguarding policies**
  The Trust is committed to ensuring adherence to the principles set out with both Safeguarding Children and Young People and Safeguarding Adults policies. These provide clear guidance so that our employees are aware how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

- **Freedom to Speak up**
  We operate a Freedom to Speak Up policy, so that all employees know that they can raise concerns, and how to raise concerns, about how colleagues or people receiving our services are being treated without fear of reprisals. This includes raising concerns about practices within our business or supply chain. This supports The Public Interest Disclosure Act 1998 (PIDA), which protects whistleblowers from detrimental treatment by their employer as a result of making a public interest disclosure.
- Arrangements are in placed to support raining concerns via the Freedom to Speak Up process also support good practice and protect workforce rights further. The Trust is also ensuring appropriate mechanisms to regularly review and monitor progress on promoting and supporting equality, diversity and inclusion within CNTW. To ensure equal opportunities we have a range of controls to protect staff from poor treatment or exploitation and we comply with all respective laws and regulations. This includes provision of fair pay rates, fair terms and conditions of employment and access to training and development opportunities.

5. Due Diligence

As part of our efforts to monitor and reduce the risk of slavery and human trafficking occurring within our supply chain, we have taken steps to enable us to:

- Establish and assess areas of potential risk in our business and supply chain.
- Monitor potential risk area in our business and supply chains.
- Reduce the risk of slavery and human trafficking occurring in our business and supply chains through the expectation that each entity in the supply chain, at least adopt ‘one-up’ due diligence on the next link in the chain as it is not practical for us to have a direct relationship with all links in the supply chain.
- Provide adequate protection for whistle-blowers.

Most of our purchases are against existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of contract which have the requirement for Suppliers to have suitable anti-slavery and human trafficking policies and processes to be in place.

We understand that our biggest exposure to Modern Slavery is associated with recruitment processes and recognise the importance of raising awareness within the business to identify any potential situations. Out Internal Audit plan also incorporates testing of elements of the recruitment process.

Due diligence is expected throughout the whole recruitment process and throughout the workers employment within the business. Procedures are reviewed to eliminate risk and gain compliance across all business locations.

6. Training and Awareness

All new internal employees must attend a local induction session which will provide information on the organisation, our values, policies, and procedures and include information associated with prevention of modern slavery. Existing staff will be made aware of modern slavery through local briefings planned through the year.

Our Procurement and Logistics service employ Chartered Procurement and Supply Professionals who are qualified as Fellows and Members of the Chartered Institute of Procurement and Supply who have passed the Ethical Procurement and Supply Final Test which is attached to this Professional Registration.

7. Indicators of Performance

We will gain assurance on the effectiveness of the steps that we are taking outlined in this statement, to ensure that slavery and/or human trafficking is not taking place within our business or supply chain and is committed to ensuring we always operate towards the best practices. By implementing and continually reviewing checks which minimise the risk of any form of modern slavery taking place within our operations, we can support the relevant government authorities in reporting any identified situations, and as such protect our business, our clients' businesses and first and foremost, our workers.

James Duncan
Chief Executive on behalf of the Board of Directors
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
May 2024

7.4 BOARD COMMITTEE TERMS OF REFERENCE - FOR APPROVAL

Louise Nelson, Committee Chair Quality and Performance Committee, Brenan Hill, Committee Chair People Com

7.4.1 - Quality and Performance Committee - Louise Nelson, Committee Chair

7.4.2 - People Committee - Brendan Hill, Committee Chair

7.4.3 - Audit Committee - David Arthur, Committee Chair

REFERENCES

Only PDFs are attached

- 7.4.1 Quality and Performance ToR Apr 24 - APPROVED DH.pdf
- 7.4.2 Terms of Reference - People Committee Mar 24 - Final.pdf
- 7.4.3. Audit Committee ToR.pdf

Quality and Performance Committee
Terms of Reference

Committee Name	Quality and Performance Committee (Q&P)
Committee Type	Standing committee of Board of Directors
Frequency	Eight times a year
Committee admin	Executive Assistant
Reporting Arrangements	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 Other Non-Executive Directors
In Attendance	Director of Communications and Corporate Affairs as appropriate Associate Director of Involvement and Lived Experience Head of Performance Delivery Governor representatives x 2 Deputy Chief Operating Officer Deputy Director of Nursing and Quality Director of AHPs and Psychological Services Chief Pharmacist Deputy Director for Safer Care
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 national requirements and standards for patient safety and learning are effective.
- 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 as the basis for evidencing 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.
- That information from patient and carer experience and involvement, including themes and trends, is informing service improvement.
- That information from staff experience, including themes and trends, is informing service improvement from a quality and safety perspective (in conjunction with the People Committee).
- The operation of all standing sub groups and delivery of any relevant reports/action plans in relation to current issues.
- Medicines safety, medicines quality, efficient use of medicines and clinical governance for the use of medicines.
- 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 including robust processes to ensure recommendations are implemented 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.
- Compliance with legal, regulatory and professional obligations, as well as good practice, relating to the handling of information, including compliance with the Freedom of Information Act 2000, UKGDPR/Data Protection Act 2018 and Data Protection and Security Toolkit.
- The Trust's open and just culture in relation to information governance (confidentiality, integrity and security breaches) and cyber incidents.
- The work of the Trust Caldicott Guardian, Data Protection Officer, Senior Information Risk Officer, Chief Clinical Information Officer, Chief Information Officer and Clinical Safety Officers in proactively and widely improving and promoting information governance and cyber security.
- Compliance with Health and Safety legislation.
- Compliance with emergency planning and resilience.

Sub Groups
Service User and Carer Reference Group Clinical Quality Governance Group Medicines Optimisation Committee Research Governance Oversight Group Infection Prevention & Control Committee Health, Safety & Security Group Clinical Effectiveness Committee Emergency Preparedness, Resilience & Response Group
Date of Committee Review: May 2024 **Date of Board approval: June 2024** **Date of previous Board approval: December 2023**

People Committee
Terms of Reference

Committee Name	People Committee
Committee Type	Standing Committee of Board of Directors
Frequency	Quarterly (the Committee will hold 2 x development sessions per year to focus on key areas)
Committee admin	Corporate Affairs Team
Reporting arrangements	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
Vice-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 Other Non-Executive Director (excluding Chair and Vice-Chair)
In Attendance	Deputy Director of Workforce and Organisational Development Equality, Diversity and Inclusion Lead Associate Director of Organisational Development Head of Workforce Development Associate Director – CNTW Academy Group Nurse Director Deputy Medical Director (revalidation) Director of AHPs and Psychological 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 by exception and with prior agreement of the Chair No deputies are permitted for Non-Executive Directors
Purpose	
To support the delivery of With you in Mind, the purpose of the Committee is to provide assurance to the Board with regard to workforce development and delivery of the 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 Workforce strategy, enabling its 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 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 risks in line with the Trust Board Assurance Framework (BAF), ensuring appropriate assurance, 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 Operational Groups to set the direction of the overall workforce change programme.
- Providing a focus on workforce plans, 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.
- Oversee the Health Inequalities agenda and implementation of Patient, Carer Race Equality Framework.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place to oversee the delivery of the Workforce strategy.

Deliverables

Assurance to the Board will be via:

- The successful implementation of the Workforce strategy and underpinning programmes and plans.
- Effective management of risk relating to the workforce portfolio providing assurance to the Board that effective controls are in place to manage workforce risks.
- Delivery of the Trust's action plans in relation to compliance, legislative and regulatory requirements relating to workforce.
- The implementation of the requirements of nationally agreed guidance.
- Compliance with relevant standards and key performance indicators relating to workforce.
- Successful programmes of work/initiatives identified from feedback of staff surveys and other indicators of staff experience, including themes and trends and updates on desired outcomes.
- Feedback from the Trust Freedom to Speak up Guardians.
- Implementation of agreed programmes of work relating to Health Inequalities, relating both to staff and wider communities.
- Feedback from other internal workforce forums.

- Progress of identified work from all standing sub-groups and delivery of any relevant programmes and plans.
- Feedback from staff Networks where appropriate.
- Ongoing progress on developing the organisational offer to support health and wellbeing programme and plans and providing assurance on the benefits of such schemes.
- Updates on the Trust Academy Programme and its contribution to the wider workforce strategy and organisational development plans.
- Progress on recommendations and actions resulting from Internal Audit outcomes relating to workforce and organisational development.

Sub Groups

Health and Wellbeing Steering Group
Health Inequalities Group
Equality, Diversity and Inclusion Steering Group

Date of Committee review: May 2024
Date of Board approval:
Date of previous Board approval: December 2023

Audit Committee
Terms of Reference

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 ("NTWS") - Internal Auditors (AuditOne) - Local Counter Fraud Services - External Auditors - Deputy Trust Secretary/Corporate Affairs Manager - 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~~ two 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. This committee has been established to provide assurance to the Board of Directors on the Trust and its subsidiaries from a Group perspective. Assurances from this committee to Trust Board will also be shared with the NTWS Board of Directors, who have an established Risk, Assurance and Governance Committee, in order to specifically review and address these assurances from an NTWS perspective.	
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~~ NHS England'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 for the identification, monitoring and control of risks. 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:

- The Trust's Risk Management Policy and associated guidance.
- 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 indicate the degree of achievement of the organisation's strategic objectives and the effectiveness of the management of principal risks through oversight of the Board Assurance Framework.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certification, including oversight of compliance with the Trust's Standards for Business Conduct Policy.
- The policies and procedures for all work related to fraud as required by NHS Counter Fraud Authority.
- The work of Internal Audit, External Audit, local Counter Fraud Specialists and other assurance functions. It will also seek reports and assurances from Executive Directors and senior managers as appropriate.
- The development, monitoring and review of the Trust's Board Assurance Framework and assurance from other Board Committees that they are fulfilling their delegated responsibility for the management of associated risks.
- The Audit Committees relationships with other Board 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 and other high-level risks identified in the Trust's Corporate Risk Register.
- 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 Counter Fraud Authority 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 NHS England'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

Whistleblowing

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 NHS England'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 of Directors and, where applicable, to the Board of NTWS on the following:

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. Whistleblowing 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: May 2024 **Date of Board approval: June 2024** **Date of previous review: June 2023**

7.5 BOARD ASSURANCE FRAMEWORK / CORPORATE RISK REGISTER REPORT

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

7.5a Board Assurance Framework-risk report Q4 23-24.pdf

7.5b CRR 16+ risks - BAF Appendix 1.pdf

Name of meeting	Board of Directors
Date of Meeting	5 June 2024
Title of report	Board Assurance Framework/Risk Register Q4 2023/24
Executive Lead	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance
Report author	Debbie Henderson, Director of Communications and Corporate Affairs

Purpose of the report	
To note	
For assurance	√
For discussion	√
For decision	√

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

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

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

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

1. Executive Summary

Understanding, monitoring, and mitigating risks are fundamental tasks in a successful Organisation. They are also seen as a basic aspect of good governance. In the Trust it is the role of the Board of Directors, delegated to the statutory Audit Committee to oversee the risk management system and obtain assurances that there is an effective system of internal control across the Trust. In addition to the responsibilities of the Audit Committee, each Board committee has responsibility for reviewing and monitoring progress against the BAF risks pertinent to their remit.

The purpose of this report is to provide an update on the position of the Board Assurance Framework and the Corporate Risk Register, progress on the management of BAF risks, key developments on the highest-level risks within the organisation and developments associated with the organisations risk management processes during the period.

2. Key issues, significant risks and mitigations

As a part of the refinement of the Trust's Risk Registers, systems and processes the Risk Management Lead has reviewed with each of the lead Executive Directors/Director, the Board Assurance Framework (BAF) Risk Register.

Section 3 of the report provides an update on the development of the BAF strategic risks, and detail of corporate risks which align to these where appropriate.

Section 4 of the report provides an overview of the high-level risks (16+) held on the Corporate Risk Register).

Section 5 of the report provides an update of work undertaken associated with the risk management systems and processes, including the review and implementation of the Trust Risk Management Policy, changes made to the Trust's Web Risk System, and further work relating to roll-out and implementation of the policy.

High-level BAF risks (specifically those scoring 16 and above) are summarised as follows. The table below also includes the current gaps in assurance as evidenced by the Trust's governance framework. The below information is used to shape Committee discussion, challenge, and scrutiny to focus on key areas and seek appropriate assurances thereon.

Quality and Performance Committee		
BAF Risk 2510	**Residual Score 16**	
Due to increased demand the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		
Gaps in Controls/Assurances include: • Demand for key pathways significantly exceeding capacity and requiring radical redesign. • Ability to recruit and develop skills to provide quicker access to evidence-based treatments. • Keeping In Touch process for service users on assessment waiting lists which the numbers		

are significantly high.

- Fully implement 4 week waits.
- Embed the Trusted Assessment concept into community services.
- Increased external demand on crisis services, specifically Right Care Right Person and NHS 111.
- Crisis and alternatives to admission.
- Lack of specialist provision for some patient groups.
- Limited availability of seven-day week service provision from both an inpatient and community perspective.
- Lack of intermediate care opportunities.

Resource and Business Assurance Committee		
BAF Risk 2545	**Residual Score 16**	
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**

Gaps in assurance

- (No longer relevant as Groups will move to new structures and in year financial position is fully mitigated)
- Absence of a medium/long-term financial plan.
- Absence of medium financial recovery trajectories by service line
- 24/25 plan is unsustainable (£3.9m deficit) and contains £6.2m of unidentified efficiencies.

People Committee		
BAF Risk 2542	**Residual Score 16**	
Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**

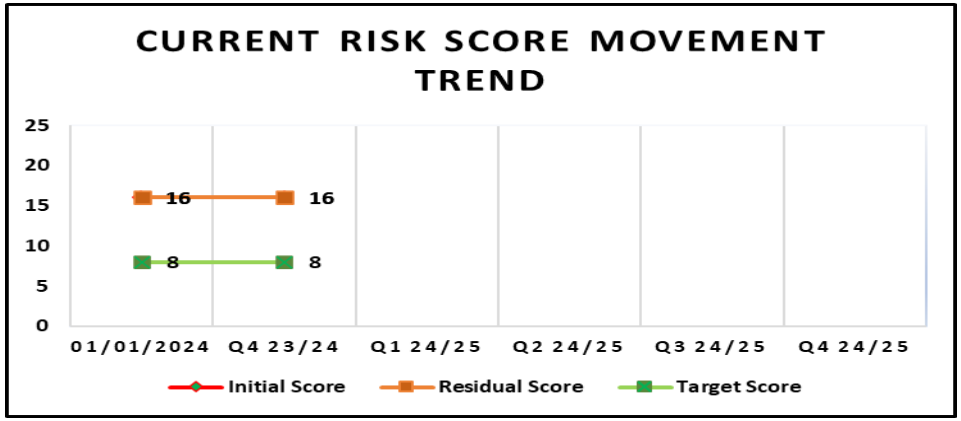
Gaps in assurance

- Absence of a sustainable workforce plan.
- Establishment control to ensure accurate recording and reporting of vacancies.
- Current workforce skills are not currently recorded and mapped against post requirements.
- Skills gaps are not identified, and adequate training put in place to address the shortfalls.
- Inclusive recruitment work has had an impact on increasing the BAME workforce but predominantly this is in lower banded posts.
- Strengthening of internal process for accessing development monies required.
- Release of staff to undertake relevant training and development opportunities is currently a challenge.
- Lack of joined up approach between appraisals and training requirements.
- Challenges ensuring the temporary workforce maintain the required skills.
- More robust recording and reporting mechanisms is required to enable leadership and management development and succession planning.

3.0 Board Assurance Framework – Quarter 4 2023/24

3.1 BAF risks aligned to the Quality and Performance Committee from Q4 2023/24

Date Opened	**01/01/2024**	**Risks Ref No:**	**2510**	**Version**	**2**	**Risk Appetite/Subcategory**	**Quality Safety -** CNTW has a **LOW** appetite for risks that may compromise safety. (6-10) - **Standards**
Next Review	**30/06/2024**						
Executive Lead	**Ramona Duguid**	**Lead Committee**	**Quality & Performance**			**Strategic Ambition**	**SA 1 - Quality care, every day**
Risk Description							
Due to increased demand the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of patient care.							
Context of the risk (narrative & background) Gaps in Controls/Assurances							
The vast majority of services provided by CNTW are community based including provision to children, adults and older people within our seven place-based areas. Whilst the demand for services has remained generally consistent in most areas, there has been a marked increase in demand within some pathways, most significantly the neurodevelopmental pathway and specialist services such as Gender. Most individuals receiving care from CNTW are open to community services only, be that crisis teams or CTT's. For a small number of service users their clinical presentation is such that they require inpatient care to augment their treatment. The ability to access beds in a timely fashion has a significant impact from an individual, family, Trust, and system perspective. Any shortfalls or deficiencies in community provision may adversely impact on the number of people requiring a period of inpatient care. Gaps in Controls/Assurances include: • Demand for key pathways significantly exceeding capacity and requiring radical redesign. • Ability to recruit and develop skills to provide quicker access to evidence based treatments. • Keeping In Touch process for service users on assessment waiting lists which the numbers are significantly high. • Fully implement 4 week waits. • Embed the Trusted Assessment concept into community services. • Increased external demand on crisis services, specifically Right Care Right Person and NHS 111. • Crisis and alternatives to admission. • Lack of specialist provision for some patient groups. • Limited availability of seven-day week service provision from both an inpatient and community perspective. • Lack of intermediate care opportunities.							

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart
Initial Score	4. Likely	4. Significant	**16**	
Residual Score	4. Likely	4. Significant	**16**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	Summary of findings				Updated
Have there been any changes to risk?	**Description**		**Yes – Description amended**		**24/04/2024**
	Owner		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**Yes 3 new controls have been added**		**24/04/2024**
	Actions Completed & Closed		**Yes actions 13091, 13089, 13087, 13085, 13090 & 14680 have been closed**		**24/04/2024**
	New Actions Added		**Yes actions 14677, 14678, 14679 & 14680 have been added**		**24/04/2024**
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
Development of a Community Oversight Group with associated task and finish groups to support clinical change to enhance input and reduce breaches.	Monthly waiting times report for Q&P demonstrating improvement in waiting times for some pathways. Minutes of Community Oversight meetings reviewing community compliance against key targets that impact upon CTTs, Crisis teams and Liaison services.
Established key task and finish groups to address the following areas: - role and function of CTTs; role and function of SPA/IRS; CYPS neuro;	Feedback from key task and finish groups which have addressed the role and function of CTTs; role and function of SPA/IRS; CYPS neuro; Trusted Assessment.

Trusted Assessment.	
Working with primary care on the development of ARRS mental health workers to reduce demand on secondary care services.	Review of monthly ARRs summaries that highlight performance and stakeholder experience.
CYP Neuro pathway review approved by EMG.	Implementation progressing across 7 places and discussed with ICB.
Established an Enhanced Bed Management service to promote timely discharge and re-drafted admission and discharge policy.	Copy of DTOC meeting minutes / reports.
ICB escalation process established for complex clinically ready for discharge patients.	Reduction in complex cases CRFD.
Reviewing the role and function of the discharge facilitator roles throughout the Trust.	Review of discharge information enabling a compare, and contrast between each of the adult mental health wards.
Working with Third Party Providers to provide additional support for hospital discharge	Review of, and reduction in the number of patients in receipt of out of area treatments.
Dashboard review highlighting clients seeking admission which includes current clinical status, location etc.	Improved alignment between community and inpatient pathways as monitored by the Programme Boards.
Active participation in the development of community transformation models within the seven place-based areas.	The Community Mental Health Steering Group receives monthly feedback from each “place” in respect of model development and progress. CNTW remains a prominent part in these developments.
Identification of seven pioneer teams (1 per place-based area) to pilot community initiatives e.g., SBAR.	Seven pioneer teams have been identified throughout the Trusts footprint. These teams will be used as a test bed to consider a broad range of initiatives linked to the community mental health development and the organisations emerging clinical model. Progress and feedback is considered at the monthly Community Mental Health Steering Group and associated performance issues are considered at the operational Community Oversight Meetings.
Development of a clinical delivery model to support more efficient and effective care delivery.	Reduction in complaints and SI's reports reflecting this available.
Reviewing working practices adopted on inpatient units to support improved flow.	The Inpatient & Urgent Care Programme of work contains a number of key projects that positively impact directly on inpatient flow and throughput within urgent care wards. Evidence of progress against each of the designated projects is contained within the monthly highlight reports that are considered at the monthly Programme Board.
Participated in the NHS England 100 Day Challenge to obtain key learnings and processes to help support more efficient and effective inpatient stays.	The national exercise is complete key elements of that work have been adopted and maintained as “business as usual – including the use of indicative discharge dates, RED to GREEN and MADE concept.
Appointed 2 Senior Case Managers to provide support and oversight of key tasks linked to effective bed management, MADE events etc.	Case Managers have successfully been appointed and are now active participants in the effective management of CNTW clients, their agreed PDP focuses on collaborative work with EBM, the support and effective management of CRFD and the support and development of effective models to manage be-spoke placement for individuals currently in the independent sector.
Development of an emerging Quality Framework for Inpatient services.	Improved performance reporting via the Integrated Performance Report (IPR).

Reviewing the role and function of the Trusts crisis teams to better align with the organisations transformational journey.	Feedback/notes from Keeping In Touch processes.
Daily Locality flow meetings in place to support patients waiting for admission.	Feedback/notes from this meeting.
Primary Care Strategy and engagement is in place.	Primary Care Strategy.

What further actions do we need to take to address the gaps in control (including target dates for completion)				
Action Number	**Action Description**	**Last Action Update**	**Person Responsible**	**Target Date**
13082	Full implementation of community transformation models within seven place-based areas - Throughout 24/25	7 x pioneering teams established and leading the transformational work at a place level.	Anna English	**30/11/2024**
13083	Continue to work with commissioner colleagues to obtain years 3 ARRS funding - Throughout 24/25	Regular meeting established for ARRS workers.	Russell Patton.	**30/11/2024**
13084	Review the resource implication of adopting the Keeping in Touch process to the Trusts assessment waiting list over and above the treatment waiting list - Q3/Q4, 23/24	Core CTT and most challenged pathways for demand to be reviewed in terms of effectiveness of keeping in touch processes.	Andy Airy	**30/06/2024**
13085	Implement optimum MDTs within Community teams - Q4, 23/24	7 x pioneering teams established and leading the transformational work at a place level.	Chloe Mann	**Closed**
13086	Undertake an analysis of the resource implications and ability of the Trust to provide a broader range of seven day a week services - Q1 24/25.	Action on hold and will be reviewed as part of annual plan priorities for 2024/25.	Russell Patton.	**31/07/2024**
13087	Ensure inpatient care provision considers key features of recent NHSE publications including: Acute inpatient mental health care for adults and older people Commissioning Framework for Mental Inpatient Services - During 23/24 and onwards.	Complete. Interim plan developed with ICB, considered at MHLDA Board 19/04/2024. CNTW work included in annual plan for 2024/25.	Russell Patton	**Closed**
13088	Undertake further work on key aspects of the 100-day challenge e.g., expansion of Red to Green, MADE and super MADE events - Q1 24/25	MADE super events will be reviewed in line with weekly ICB escalation meeting for CRFD.	Russell Patton.	**31/07/2024**
13089	Work with NTW Solutions on the development	Estates plan for priority inpatient areas	Russell Patton.	**Closed**

	of an Integrated Inpatients Estates Plan - Q4 23/24.	agreed, linked to CAV, Hadrian Clinic and Carleton Clinic inpatient areas for 2024/25. Ongoing maintenance to be reviewed through the environmental safety steering group.		
13090	Pursue business case opportunities to optimise bed numbers in key geographical service areas - Q3 23/24.	Complete for 2024/25 – bed numbers agreed as part of operating plan for 2024/25.	Russell Patton.	**Closed**
13091	Work with the ICB and NHSE on the utilisation of any available resources to develop inpatient alternatives and or intermediate care options Q4 23/24.	This work will be progressed through the ICB IP Transformation Group.	Russell Patton	**Closed**
13092	Work with the ICB and other stakeholders on the development of a sustainable inpatient bed model for the system, promoting the concept of Centres of Excellence - Throughout 24/25	ICB interim plan drafted and considered at MHLDA board 19/04/2024. Further work on sustainable provision across the NENC to be progressed as part of this plan.	Ramona Duguid	**30/11/2024**
14677	Crisis work programme to be reviewed in light of community transformation and urgent care requirements.	Report to be presented to EMG on crisis work programme and priorities.	Ramona Duguid	**30/06/2024**
14678	Successfully transition away from CPA – **during 2024/25**	Review outputs from pioneering teams to inform keyworker and MDT requirements.	Rajesh Nadkarni.	**01/09/2024**
14679	Successfully implement 111 service delivery model to support the inpatient pathway – **Q1 24/25**	NHS 111 go live slightly delayed.	Ramona Duguid	**30/04/2024**
14680	Respond effectively to any impact of the developing RCRP initiative – **Q4 23/24**	Complete. RCRP highlight reports in place with system strategic oversight with the ICB.	Sarah Rushbrooke	**Closed**

Internal Audit 2023/2024						
Quality & Performance Committee	**2023/2024**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	

This risk is not aligned to any Internal Audits for Q4					
Clinical Audit Plan					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Corporate Risk Register risks alignment to the Quality and Performance Committee BAF risks

Corporate Risk Register - 1287 Aligned to BAF Risk – 2510		
Directorate/Group Risk 1287	**Residual Score 16**	
Non-Compliance with Discharge Summaries being sent to GP within 24 hours of patient discharge. RiO including Medication pages are not being kept up to date as per CNTW policy. Information transferred to the Mental Health Discharge Summary may not be accurate.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in Controls		
• Internal Audit of Medication Summaries and Discharge Summaries to commence in Q1 2024/25 • Improve compliance with the Discharge Summary being sent to GP's within 24hrs of the discharge date. • Locality Attendance of medic at the Trustwide Discharge Summaries Meeting.		

Risk 1287 was discussed at the meeting of Executive Management Team held 22 April and it was agreed to review this risk with a view to it being de-escalated to clinical business unit level. This will be reflected in the Q1 2024/25 report.

Corporate Risk Register - 2463

Aligned to BAF Risk 2510		
Corporate Risk register 16+ Risk 2463	**Residual Score 16**	
Due to the location of Yewdale it is difficult to recruit staff to work there and it is isolated from the main hospital site (Carleton Clinic). Because of these factors there is an ongoing risk safer staffing levels will not be met and/or that the staffing compliment will not contain the MDT skill mix required to consistently provide safe and effective patient care. This is likely to happen and could have a major impact on patient care.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in Controls		
• Ongoing discussions with the execs and ICB re: future of the ward and provision of care in West Cumbria		

Date Opened	**01/01/2024**	**Risks Ref No:**	**2511**	**Version**	**2**	**Risk Appetite/Subcategory**	**Quality Effective/Experience -** CNTW has a **LOW** appetite for risks that may compromise the delivery of outcomes, or risks that may affect the experience of, our service users (6-10) - **CQC**
Next review	**30/06/2024**						
Executive Lead	**Sarah Rushbrooke**	**Lead Committee**	**Quality & Performance**			**Strategic Ambition**	**SA 1 - Quality care, every day**

Risk Description

Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.

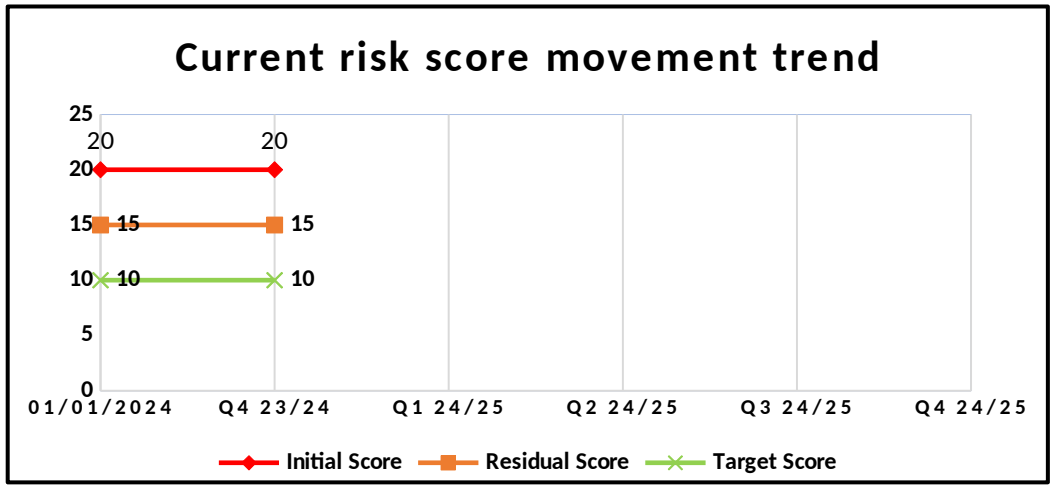
Context of the risk (narrative & background) Gaps in Controls/Assurances

The Trust has not had a CQC Comprehensive inspection since 2018. It is likely this will happen in 2023/24 so we are required to demonstrate compliance against the CQC registration, regularity requirements and Key Lines of Enquiry. There has been slow progress in closing some of the existing Must Do actions, particularly following the transfer of Cumbria services in 2019. Change of CQC leadership team and Executive with CQC responsibility. Gaps in Controls/Assurance include:

- Newly emerging relationship with new CQC team and new Executive team and confidence in the emerging relationship with new CQC team.
- Closure of action plans relating to new buildings and environment may slip as works are being delayed.

	Likelihood	Impact	Score
Initial Score	4. Likely	5. Major	**20**
Residual Score	3. Possible	5. Major	**15**
Target Score	2. Unlikely	5. Major	**10**

Score
Residual Risk Score Movement Chart



Key questions:	Summary of findings	Updated

Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**Yes one control has been added**		**28/03/2024**
	Actions Completed & Closed		**No**		
	New Actions Added		**No**		
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

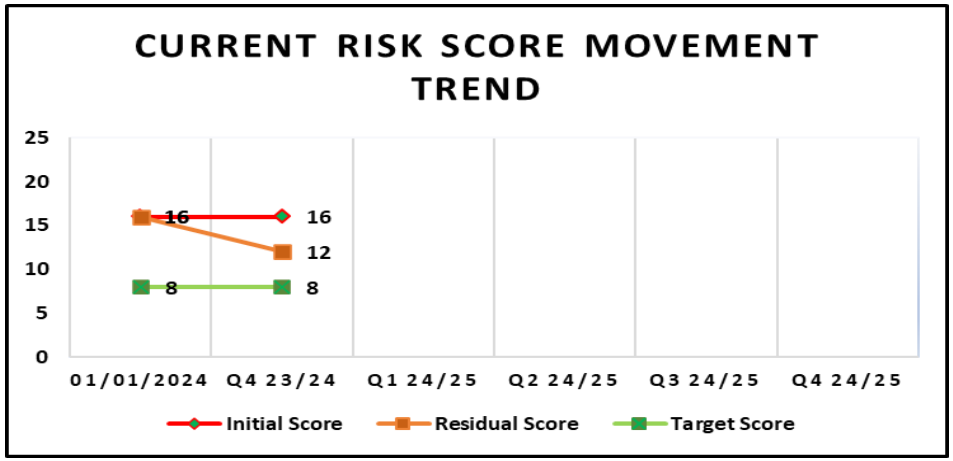
What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**
Monthly CQC Compliance meeting and fortnightly Steering Groups in place	Minutes from meetings show a reduction in CQC Action plans from 51 - 21
MHA Reviewer Visits in place - sharing of reports and aligning actions to CQC Must Dos/themes.	Improved outcomes following MHA reviewer visits and actioning of recommendations. Reports and aligning actions to CQC Must Dos/themes are available.
Monthly reporting of Must Do actions through Q&P - reducing number and action plans.	Feedback / updates on areas of improvement and good practice at CQC Compliance group and BDG - Q&P.
Programme of mock CQC Inspections led by Senior Clinician and CQC compliance lead.	Feedback/Reports of completed mock CQC Inspections carried out across the Trust. Reporting themes to Q&P Committee to ensure continued focus.
CQC Relationship Meetings bi-monthly.	Minutes from this meeting are available.
Learning and bench marking through oversight of other organisational CQC Inspection Reports.	Copy of report outlining actions for learning and improvement from other CQC Inspection Reports. .
CQC Update sessions delivered at Ward managers Community of Practice - August 2023	Increased awareness of preparedness for CQC inspections, and actions identified.
CQC inspection preparedness programme in place. Task and Finish Groups include Governor representation	CQC Inspection Steering Group and Compliance Group have been merged to further align improvement activity. Task & Finish Groups established in August 2023 and are now well embedded. Feedback provided to CQC Compliance Group which includes input from Governors as service users, carers, and staff.
Peer Review visits	Feedback from visits carried out and improvements undertaken from actions noted.
Inspection preparedness audit	Internal Audit conducted a risk-based audit of the Trust's preparedness for a comprehensive CQC inspection. Audit gave good level of assurance.
What further actions do we need to take to address the gaps in control	

(including target dates for completion)				
Action Number	**Action Description**	**Last Action Update**	**Person Responsible**	**Target Date**
13094	Continue with regular informal connection and formal meetings with CQC leadership team - ongoing throughout 2023/24	There has been a further change in CQC relationship team however formal meetings have continued bi-monthly.	**Vicky Wilkie**	**30.06.24**
13095	Sharing of good practice and areas of improvement - ongoing throughout 2023/24	Monthly presentations to CQC Compliance Group continue.	**Sarah Rushbrooke**	**30.06.24**
13096	Quarterly updates to Board on progress against closure of action plans - ongoing throughout 2023/24	Quarterly updates continue. A further 2 Must Do action plans have been closed since December 2023.	**Sarah Rushbrooke**	**30.06.24**
13097	Updates on building works to CQC - ongoing throughout 2023/24	One Must Do action plan linked to environmental shortfalls to be closed in March 2024, 2 remain open linked to the CEDAR project and improvements in North Cumbria.	**Vicky Wilkie**	**30.06.24**
13098	Delivery of CQC 'every day is a quality day' preparedness programme - Q3/Q4 2023/24	Video message completed focussing on encouragement and thanks to staff. Development of shout up board for the intranet page for staff to share what they are proud of. Future comms to be linked to areas of improvement – long-term comms plan developed and ongoing.	**Vicky Wilkie**	**30.06.24**

Internal Audit 2023/2024						
Quality & Performance Committee	**2023/2024**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	

This risk is not aligned to any Internal Audits for Q4					
Clinical Audit Plan					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2512**	**Version**	**2**	**Risk Appetite/Subcategory**	**Quality Safety -** CNTW has a **LOW** appetite for risks that may compromise safety (6-10) – **Patient Safety**
Next Review	**30/06/2024**						
Executive Lead	**Rajesh Nadkarni**	**Lead Committee**	**Quality & Performance**			**Strategic Ambition**	**SA 1 - Quality care, every day**
Risk Description							
Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern.							
Context of the risk (narrative & background) Gaps in Controls/Assurances							
The Trust has robust incident reporting and review processes in line with the Serious Incident Framework (2015) which provide assurance to the board and external partners / regulators. The new Patient Safety incident response framework (PSIRF) requires Trusts to change their focus of incident reviews to increase learning and improvement. This requires a change in the incident processes and reviews. There are risks if these changes are not successfully implemented. Gaps in Controls/Assurances include: - • Implementation of PSIRF will require extensive engagement and training of staff to ensure that their practice changes to align with the new systems, processes and culture changes. • Outcome measures will need to move from numbers and data around compliance with timescales to assessing how learning is shared and improvements embedded.							
	Likelihood	**Impact**	**Score**	**Score**			

				Residual Risk Score Movement Chart
Initial Score	4. Likely	4. Significant	**16**	
Residual Score	3. Possibly	4. Significant	**12**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	**Summary of findings**				**Updated**
Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**Yes - Residual risk has been reduced from 16 to 12**		**28/03/2024**
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**No**		
	Actions Completed & Closed		**No**		
	New Actions Added		**Yes – action 14332 has been added**		**28/03/2024**
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**
PSIRF Core Project Team in place led by Rajesh Nadkarni (with Internal Audit input)	Monitoring and review of the PSRIF project plan to ensure implementation plan remains on track
Clear governance and assurance in place on PSIRF implementation.	Reduction in the number of SIs; Independent Investigations and complaints reports available.

Training needs analysis in place	Training dashboards where training needs are identified and where compliance is not being met, and where compliance is being achieved.
Communication plan in place (including staff, Board, Governors, service users and carers and workforce).	Copy of plan is available. Plan ensured awareness across the organisation.
CNTW went live with PSIRF on 22nd January. New systems and processes were implemented. There will be a period of dual running of the SIF and PSIRF systems whilst we transition and complete all those that occurred under the SIF framework.	Monitoring and review of period of dual running of the SIF and PSIRF systems whilst we transition and complete all those that occurred under the SIF framework.

What further actions do we need to take to address the gaps in control (including target dates for completion)

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13114	Outcome measures to be developed - Nov 23	Outcome measures are in development which encompass all 4 aims of PSIRF. Further work is needed – extend date to end of June 24	**Claire Thomas**	**30.06.24**
13115	Training of staff in new investigation methods and engagement - to start in Nov 23 with planned trajectories.	Training for staff in using a systems approach to investigating incidents was launched in January 24. Sessions have been well attended and over 600 staff have been training – I think this needs to remain open whilst further staff complete this. If the target date can be extended to end of June 24	**Claire Thomas**	**30.06.24**
14332	Trust Leadership Forum session planned to take place in June 2024 to discuss organisational culture including sessions on just / learning culture.	N/A new action added.	**Claire Thomas**	**30.06.24**

Internal Audit 2023/2024

Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	

					BAF/SA
This risk is not aligned to any Internal Audits for Q4					
Clinical Audit Plan					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2543**	**Version**	**2**	**Risk Appetite/Subcategory**	**Model of Care -** CNTW has a **MODERATE** appetite for risks associated with the development of the organisations model of care that does not compromise quality of care (12-15) - **Services**
Next review	**30/06/2024**						
Executive Lead	**Ramona Duguid**	**Lead Committee**	**Quality & Performance**			**Strategic Ambition**	**SA 2 - Person-led care, when and where it is needed**

Risk Description

Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services.

Context of the risk (narrative & background) Gaps in Controls/Assurances

The Trust has in place an annual plan to support the delivery of its strategic objectives. This includes specific programmes of work in place to deliver the changes in the model of care delivered across CNTW. This includes how the Trust is working with the ICB on the MHLDA strategic work across the NENC.

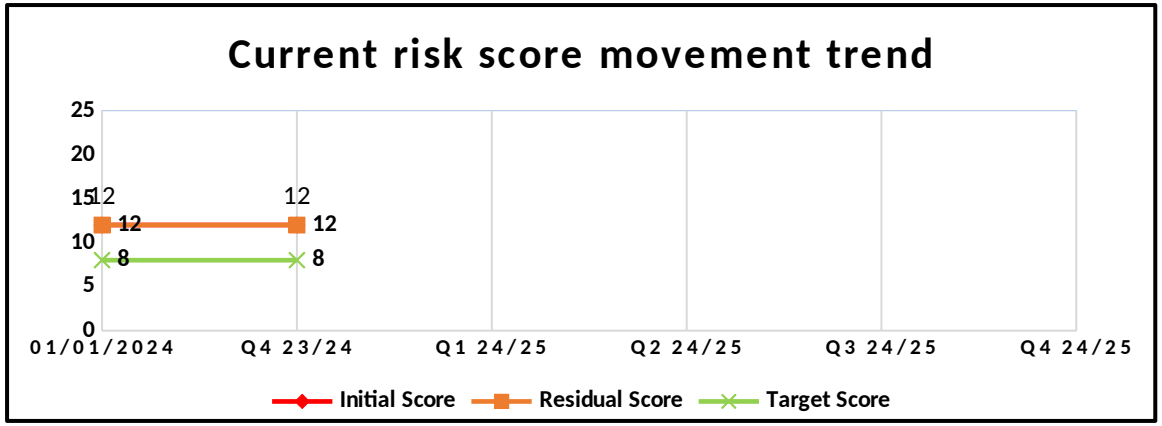
There is a risk that the ability to deliver the transformations required across the Trust affects the quality of services provided and sustainability of services.

Gaps in control

- Level of stability with ICB restructure and impact on place teams.
- Detailed financial plans to deliver some of the transformation plans not mature enough.
- Learning Disability focus on transforming care requires refresh across the system.
- Pressures and demand on other partners – local authority and primary care impacting on the ability to achieve transformational change.

	Likelihood	Impact	Score
Initial Score	3. Possible	4. Significant	**12**
Residual Score	3. Possible	4. Significant	**12**
Target Score	2. Unlikely	4. Significant	**8**

Score
Residual Risk Score Movement Chart



Key questions:	Summary of findings				Updated
Have there been any changes to risk?	Description		Yes		24/04/2024
	Owner		No		
	Residual Score		No		
	Is risk to be closed		No		
Have actions progressed?	Control and Assurances added.		Yes 2 new controls have been added		24/04/2024
	Actions Completed & Closed		Yes actions 13534, 13533, 13532, 13530, 13531 & 13535 have been completed		24/04/2024
	New Actions Added		Yes actions 14690, 14688 & 14689 have been added		24/04/2024
Do all actions have a timescale?	Yes	Were risks reviewed in a timely manner?	Yes	Expected date risk to be mitigated and brought within the risk category appetite.	2024/25

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
The Trust has established discreet Programmes of work to oversee transformational change within our clinical services. Each of these Programmes are supported by discreet projects of work.	Monitoring progress against project plans in place with leads and delivery dates. These are being refreshed for 24/25 following the planning work which has been completed with TLF and the new group structure coming into go live.
We are engaging with key internal stakeholders via the Trust Leadership Forum, Ward Managers Meetings, Community of Practice, Service User and Carer Forums etc.	Greater and wider understanding of the key programmes and project outputs by Trust staff.
Development of a Primary Care Partnership Plan	7 Pioneer Teams developed. Evidence of improved engagement via specific workshop attendance, levels of feedback etc.
Executive Representation at key ICB governance and leadership meetings	Greater influence over the system wide Mental Health, Learning Disability and Autism agenda evidenced by inclusion of MHLDA in objectives and plans at ICS/ICB level.
Realignment of CNTW operating structure to focus delivery on key transformational areas with commissioners (ICB and provider collaborative).	Structure go live April 2024.

What further actions do we need to take to address the gaps in control (including target dates for completion)

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
14688	Continue to influence the NENC ICB priorities to support the implementation of CNTW transformational plans.	14688	Ramona Duguid	30.06.24
14689	Chief Executive review of the system forum to support the transforming care programmes of work in place with the ICB.	Revised leadership group for the system to be established.	James Duncan	31.05.24
14690	CNTW Integrated Performance Report being reviewed for 24/25 to ensure impact on deliver of the plan can be demonstrated against key metrics and critical milestones to be delivered for the year.	Executive Director review of IPR 29.04.25	Ramona Duguid	31.05.2025

Internal Audit 2023/2024					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Corporate Risk Register alignment to the Quality and Performance Committee BAF risks

Corporate Risk Register - 2508 Aligned to BAF risk 2543		
Corporate Risk register 16+ Risk 2508	**Residual Score 16**	
A number of GP practices have made the decision to withdraw from shared care arrangements.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in Controls		
• Rajesh Nadkarni to escalate the issue around shared care arrangements with Neil O'Brien ICB. Kate (PCN)		

3.2 New BAF risks aligned to Resource and Business Assurance Committee from Q4 2023/24

Date Opened	**01/01/2024**	**Risks Ref No:**	**2540**	**Version**	**2**	**Risk Appetite/Subcategory**	**Financial -** CNTW has a **LOW** appetite for risks that impact on the possibility of financial loss and our ability to deliver care and treatment in the longer-term (6-10) – **Sustainability**
Next Review	**30/06/2024**						
Executive Lead	**Kevin Scollay**	**Lead Committee**	**Resource and Business Assurance Committee**			**Strategic Ambition**	**SA 3 – A great place to work**

Risk Description

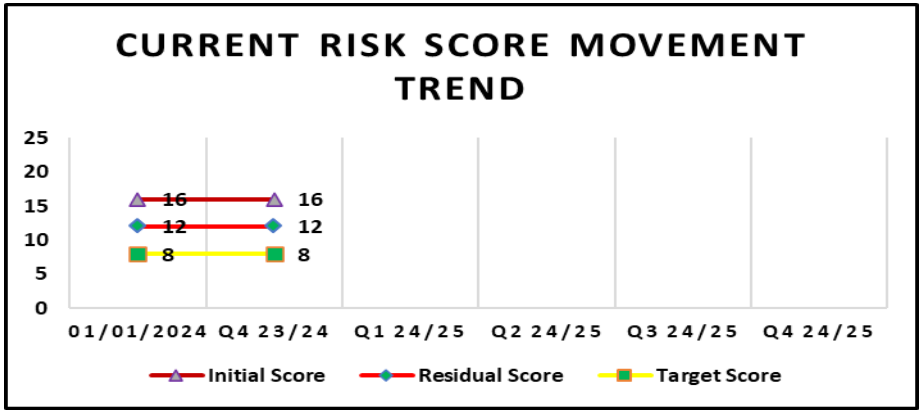
Risk of increased staffing costs from use of temporary staff impacting on quality of care and financial sustainability.

Context of the risk (narrative & background) Gaps in Controls/Assurances

For several years, it has been a challenge to recruit into some posts. This has resulted in a high use of locum/agency in these areas. As well as the financial impact, this impacts on the quality and safety of service and lack of continuity of care for a service user population where this is important.

Temporary staffing costs, particularly agency usage, increased sharply during the 2021/22 financial year. Temporary staff are less familiar with Trust procedures and culture, which increases the chances of incidents which impact on the quality of care for our service users. The increase in usage of temporary staffing resource is also financially unsustainable. Rules around agency usage are also regularly breached from a regulatory perspective such as price cap breaches, although off framework usage has reduced to zero and aggregate expenditure is now below the cap. These breaches bring with them a risk of regulatory intervention by NHSE. Gaps in Controls/Assurances include: -

- Absence of a long-term sustainable workforce plan.
- Absence of a long-term sustainable financial plan.
- Review of the Trust's clinical model / care and treatment model. Clarity on links between financial planning and delivery of the key programmes of work – specifically financial and workforce trajectories associated with the changes to the model of care, the conceptual links are fully understood.

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart
Initial Score	4. Likely	4. Significant	**16**	
Residual Score	3. Possible	4. Significant	**12**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	Summary of findings				Updated
Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**No**		
	Actions Completed & Closed		**Yes actions 13516, 13517, 13518 & 13519 have been closed**		**28/03/2024**
	New Actions Added		**Yes action 14325 has been added.**		**28/03/2024**
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
Group based agency control meetings.	Minutes from meeting regarding group based agency control.
Quarterly review of agency expenditure via finance reporting at RBAC	Reports and Minutes from RBCA
Reporting of agency expenditure via BDG	Minutes from the BDG where agency expenditure discussed.
Monthly Board scrutiny and review at Board development sessions	Feedback/report from development sessions

Reporting of agency expenditure via EMG.	Minutes from the EMG where agency expenditure discussed.
Quarterly well led framework meetings include reporting around agency usage	Implementation of NHSE controls e.g., nonclinical and off framework actions.

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13516	Reduce agency expenditure to below cap levels.	Closed	**Kevin Scollay**	**Closed**
13517	Eliminate off framework agency usage.	Closed	**Kevin Scollay**	**Closed**
13518	Eliminate nonclinical agency usage	Closed	**Kevin Scollay**	**Closed**
13519	To develop plans to reduce agency spend to 1 million a month by 31.03.24	Closed	**Ramona Duguid**	**Closed**
14325	Enhance monitoring of price cap breaches to support development of action plans to eliminate price cap breaches	N/A new action	**Christopher Cressey**	**30.06.24**

Internal Audit 2023/2024

Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan

Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2541**	**Version**	**2**	**Risk Appetite/Subcategory**	**Climate & Ecological Sustainability -** CNTW has a **MODERATE** appetite for risks that may result in the harming of the environment which could lead to affect the physical and mental health of the populations we serve. 12-15 – **Green Plan**
Next Review	**30/06/2024**						
Executive Lead	**Kevin Scollay**	**Lead Committee**	**Resource and Business Assurance Committee**			**Strategic Ambition**	**SA 4 – Sustainable for the long term, innovating every day**

Risk Description

Risk that the Trust does not deliver the objectives of its Green Plan affecting the physical and mental health of current and future generations.

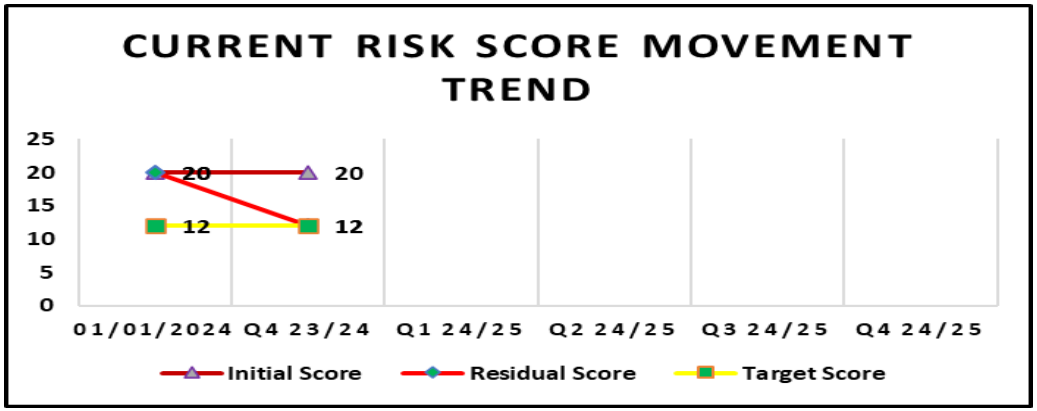
Context of the risk (narrative & background) Gaps in Controls/Assurances

Following a declaration in March 2020 of a climate and ecological emergency, the Trust recognised that climate and ecological change are affecting the physical and mental health of current and future generations.

The Trust must mitigate further damage by adopting the principles of sustainable healthcare and reducing carbon emissions from activities in accordance with our Green Plan trajectories (net zero by 2040) and adapt our infrastructure and preparedness for increased likelihood of extreme weather events. Gaps in Controls/Assurances include: -

- Limited reporting on progress against the agreed Green Plan.
- Clarity on the availability of capital funding.
- Capacity issues within the team to progress the actions required against the Green Plan.

	Likelihood	Impact	Score	Score

				Residual Risk Score Movement Chart
Initial Score	5. Almost Certain	4. Significant	**20**	
Residual Score	5. Almost Certain	4. Significant	**12**	
Target Score	3. Possible	4. Significant	**12**	

Key questions:	**Summary of findings**				**Updated**
Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**Yes score has reduced from 20 to 12 at last review due to partial delivery of green plan**		**28/03/2024**
	Is risk to be closed		**No - The Broad approved the de-escalation of this BAF risk to a directorate level risk.**		
Have actions progressed?	**Control and Assurances added.**		**No**		
	Actions Completed & Closed		**Yes action 13521 has been closed**		**28/03/2024**
	New Actions Added		**No**		
Do all actions have a timescale?	**Yes/No**	**Were risks reviewed in a timely manner?**	**Yes/No**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**
Commitment to sustainable healthcare and net zero carbon emissions through Board Statement, Trust Green Plan, the new Trust strategy, 'with you in mind' and through the CNTW Climate Health programme.	Via Green Plan monitoring.
Named CNTW Board lead for sustainability in place alongside Trust lead and trust clinical lead. NTW Solutions has sustainability included	Via Green Plan monitoring.

within its strategy and has created a new 'Energy and Low Carbon' manager.	
Implementation of Trust Green Plan.	Monitored through EMG and RABAC and inclusion on internal audit plan.
Trust business cases include a requirement to articulate how the proposed change supports sustainable healthcare.	Monitored through business case processes.
Influencing the mental health and learning disability sector re sustainable healthcare through the Green Minds Network and other opportunities.	Green Minds Network

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13520	Availability of capital funding to implement decarbonisation schemes. Make applications for new grant funding. Align Green Plan deliverables with existing capital funding availability.	Applications have been made and have been rejected. Further applications will be made as and when funding becomes available.	Kevin Scollay	**31.03.25**
13521	Monitoring of Green Plan – new arrangements to be developed post Governance Review.	Green plan updates will be provided to BDG Finance going forwards. Closed	Anna Foster	**Closed**
13522	Address resource issues within NTW Solutions. Proposal to be developed and taken to EMG for approval including the recruitment of longstanding vacant Energy Manager post.	Address resource issues within NTW Solutions. Proposal to be developed and taken to EMG for approval including the recruitment of longstanding vacant Energy Manager post. Unfortunately, we have been unable to recruit into the Energy Manager post. The structure is currently: • Energy and Sustainability manager (Cara Tabuku) • Decarbonisation Lead (Paul McCabe). • Sustainability Lead • Energy Manager We are currently reviewing the option to utilise the Energy Manager post as an Energy Officer (Trainee) post in order to broaden the range of potential candidates.	Matthew Lessells	**30.06.24**

		This is being explored. We also now require too go to recruitment to replace the Sustainability Lead (Sarah Neil) due to Sarah accepting a role in another NHS organisation. This vacancy is due to be advertised W/C 25th March 24.		

Internal Audit 2023/2024					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2545 Risk 8**	**Version**	**2**	**Risk Appetite/Subcategory**	**Finance -** CNTW has a **LOW** appetite for risks that impact on the possibility of financial loss and our ability to deliver care and treatment in the longer-term (6-10) – **Sustainability**
Next Review	**30/06/2024**						
Executive Lead	**Kevin Scollay**	**Lead Committee**	**Resource and Business Assurance Committee**			**Strategic Ambition**	**SA 4 – Sustainable for the long term, innovating every day**

Risk Description

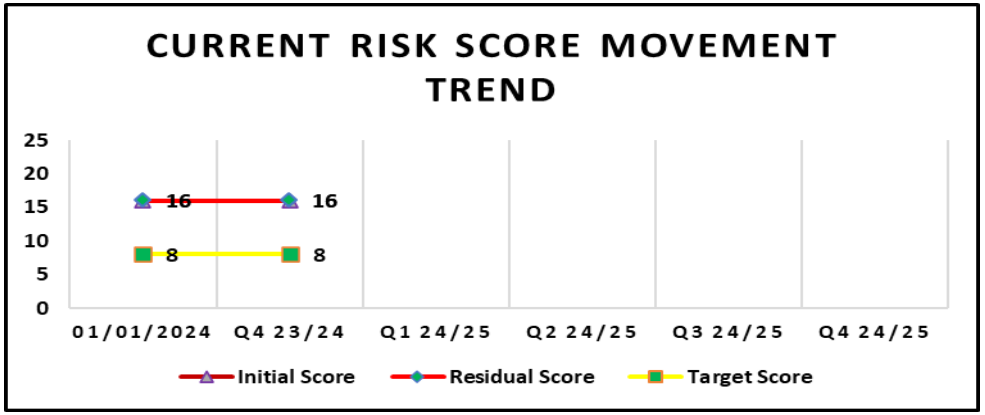
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.

Context of the risk (narrative & background) Gaps in Controls/Assurances

The Trusts is currently operating with an underlying financial deficit and has included assumptions within its current year financial position to eliminate the deficit which were unidentified at the start of the financial year. The Trust continues to operate within a challenging and uncertain financial environment although the risk within the 23/24 financial year has been mitigated.

The Trust is at risk of operating with insufficient financial resources and be subject to regulatory action for failing to meet financial duties if it is unable to reduce expenditure run rates. Gaps in Controls/Assurances include: -

- ~~(No longer relevant as Groups will move to new structures and in year financial position is fully mitigated)~~
- Absence of a medium/long-term financial plan.
- Absence of medium financial recovery trajectories by service line
- 24/25 plan is unsustainable (£3.9m deficit) and contains £6.2m of unidentified efficiencies

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart
Initial Score	4. Likely	4. Significant	**16**	
Residual Score	4. Likely	4. Significant	**16**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	Summary of findings				Updated
Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**Yes one new control has been added**		**28/03/2024**
	Actions Completed & Closed		**Yes actions 13541, 13542 & 13543 have been closed**		
	New Actions Added		**Yes actions 14326, 14327 & 14328 have been added**		
Do all actions have a timescale?	**Yes/No**	**Were risks reviewed in a timely manner?**	**Yes/No**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
Group based agency control meetings.	Monthly reporting of financial performance via BDG.
Agency control procedures.	Copy of procedures
Implementation of NHSE controls e.g., nonclinical and off framework actions.	Minutes from quarterly well led framework meetings of overall financial position.
Reduction of unidentified CIP within Trust financial plans	Monthly Board scrutiny and review at Board development sessions
Ongoing management of in year financial position through exceptional	Minutes from this meeting will be available

escalation meetings.	
Development of Group specific in year recovery plans and actions.	Monthly Board scrutiny and review at Board development sessions
Identification of underlying financial deficit to support medium term planning	Quarterly review of overall financial position via finance reporting at RBAC.
CNTW 2023-24 15 Locality Budgetary Control - Locality & Support services level. Final report dated 09.02.024	CNTW 2023-24 15 Locality Budgetary Control - Locality & Support services level final report, provides a substantial assurance that the risks identified are managed effectively. Compliance with the control framework was also found to be taking place.

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13541	Development of in year recovery plan for Central locality.	Central locality remains significantly overspent. Given the movement into the new Groups and the financial risk for 23/24 has been fully mitigated for the Trust, this action (which relates to the in year financial position) can be closed.	**Anna English**	**Close**
13542	Identification of Trust wide drivers of the deficit. Medium term financial plan	Complete - the Trust has fully engaged with the ICS MTFP work. The Trusts HRD and FD are leads for the ICS wide workforce workstream.	**Chris Cressey**	**Close**
13543	Return completed and shared with NHSE. To be brought for Board discussion in September.	Brought to Board in September action completed.	**Kevin Scollay**	**Close**
14326	Medium term financial recovery trajectories to be agreed to support medium term financial planning.	N/A new action	**Chris Cressey**	**30.06.24**
14327	Additional efficiencies to be identified to remove the £6.2m unallocated efficiencies included in the financial plan.	N/A new action	**Chris Cressey**	**30.06.24**
14328	Extend existing Financial Delivery Plan by extending the planning horizon by 2 years and enhancing reporting on efficiency delivery.	N/A new action	**Chris Cressey**	**30.06.24**
Internal Audit 2023/2024				

Resource and Business Assurance Committee	2023/2024				
	Q1	Q2	Q3	Q4	BAF/SA
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
Resource and Business Assurance Committee	2023/2024				
	Q1	Q2	Q3	Q4	BAF/SA
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2546**	**Version**	**2**	**Risk Appetite/Subcategory**	**Estates Infrastructure -** CNTW has a MODERATE risk appetite for poor estates and infrastructure that may impact on our ability to deliver care in a safe environment 12-15 – **Capital Funding**
Next Review	**30/06/2024**						
Executive Lead	**Kevin Scollay**	**Lead Committee**	**Resource and Business Assurance Committee**			**Strategic Ambition**	**SA 4 – Sustainable for the long term, innovating every day**

Risk Description

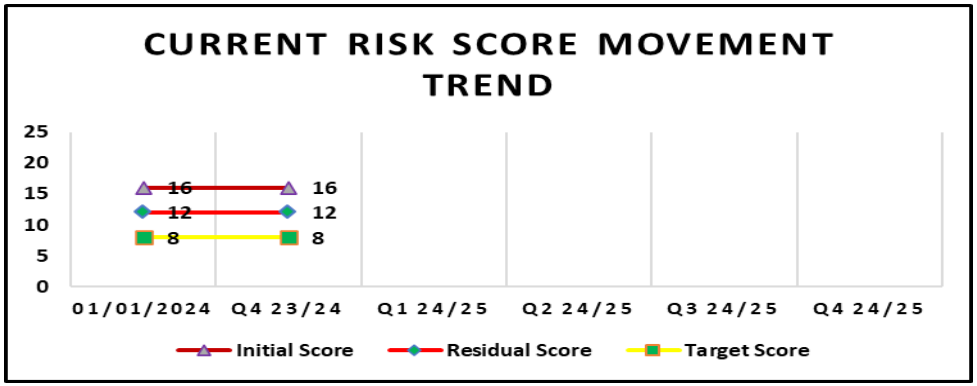
Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure.

Context of the risk (narrative & background) Gaps in Controls/Assurances

The regulatory framework within which the NHSE operating is increasingly challenging i.e., reducing levels of capital resource. These reductions in resource may lead to harm to service users if not managed effectively. This includes the risk of failing to properly maintain the estate to sufficient standards to properly care for our service users. Gaps in Controls/Assurances include: -

- The CEDAR scheme now has approval by Treasury.
- Clarity of the how the Trust's medium/long-term Estates Strategy can be afforded from a cash and a CDEL perspective.

- The capital plan for 24/25 has c£2.4m of pressure identified.

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart
Initial Score	4. Likely	4. Significant	**16**	
Residual Score	3. Possible	4. Significant	**12**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	Summary of findings				Updated
Have there been any changes to risk?	**Description**	**No**			
	Owner	**No**			
	Residual Score	**No**			
	Is risk to be closed	**No**			
Have actions progressed?	**Control and Assurances added.**	**No**			
	Actions Completed & Closed	**Yes actions 13546 & 13545 have been closed**			**28/03/2024**
	New Actions Added	**Yes action 14329 has been added**			**28/03/2024**
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
Capital Plan for 23/24 agreed by the Board as part of the Annual Financial Plan, with outline plans for subsequent years included.	Establishing capital budgets and having clarity on the capital programme ensures that clear plan is in place to continue to modernise the estate with clear means of resourcing. The capital programme is monitored through use of the finance reporting

	to a number of groups/committees to ensure the Trust is well sighted on the capital programme and can manage this effectively. Capital resources have been provided through this budget for 23/24.
Managing working capital (cash) effectively	Monitoring of cash levels via finance report to ensure cash levels are sufficient to resource the capital plan.
Secure funding and authority to implement changes to Estate through the CEDAR programme. • OBC approval (including inherent improvement in revenue position) • Bridging Loan Secured • Business Case Addendum	Approval of the business case and associated funding provides the required resources to adequately fund the CEDAR programme. Treasury approval is still outstanding for the business case addendum, but NHP and NHSE approval has been secured.
CEDAR Programme Board established with key partners	Ongoing operation of the CEDAR board ensures governance is in place to manage key risks and provide oversight of the project. Reporting into the Board of Directors evidence this is operating effectively on an ongoing basis.

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13545	Business case addendum for CEDAR to be approved by NHP/Treasury	This action has now been completed	Kevin Scollay	**Closed**
13546	Addendum has been submitted and the Trust is currently engaged in responding to questions from NHP (KS)	This action has now been completed	Kevin Scollay	**Closed**
14329	Work with ICS colleagues to identify a means of mitigating CDEL pressures across the ICS, including those within the Trust plan.	N/A new action	Kevin Scollay	**31.03.25**

Internal Audit 2023/2024						
Resource and Business Assurance Committee	**2023/2024**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	
This risk is not aligned to any Internal Audits for Q4						

Clinical Audit Plan	
Resource and Business Assurance Committee	**2023/2024**

	Q1	Q2	Q3	Q4	BAF/SA
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2546**	**Version**	**2**	**Risk Appetite/Subcategory**	**Estates Infrastructure -** CNTW has a MODERATE risk appetite for poor estates and infrastructure that may impact on our ability to deliver care in a safe environment 12-15 – **Capital Funding**
Next Review	**30/06/2024**						
Executive Lead	**Kevin Scollay**	**Lead Committee**	**Resource and Business Assurance Committee**			**Strategic Ambition**	**SA 4 – Sustainable for the long term, innovating every day**

Risk Description

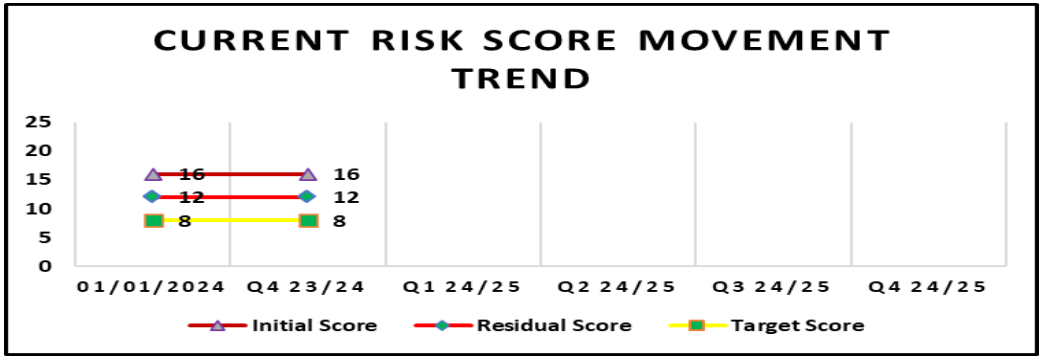
Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure.

Context of the risk (narrative & background) Gaps in Controls/Assurances

The regulatory framework within which the NHSE operating is increasingly challenging i.e., reducing levels of capital resource. These reductions in resource may lead to harm to service users if not managed effectively. This includes the risk of failing to properly maintain the estate to sufficient standards to properly care for our service users. Gaps in Controls/Assurances include: -

- The CEDAR scheme now has approval by Treasury.
- Clarity of the how the Trust's medium/long-term Estates Strategy can be afforded from a cash and a CDEL perspective.
- The capital plan for 24/25 has c£2.4m of pressure identified.

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart
Initial Score	4. Likely	4. Significant	**16**	
Residual Score	3. Possible	4. Significant	**12**	
Target Score	2. Unlikely	4. Significant	**8**	



Key questions:	Summary of findings				Updated
Have there been any changes to risk?	Description		No		
	Owner		No		
	Residual Score		No		
	Is risk to be closed		No		
Have actions progressed?	Control and Assurances added.		No		
	Actions Completed & Closed		Yes actions 13546 & 13545 have been closed		28/03/2024
	New Actions Added		Yes action 14329 has been added		28/03/2024
Do all actions have a timescale?	Yes	Were risks reviewed in a timely manner?	Yes	Expected date risk to be mitigated and brought within the risk category appetite.	2024/25

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
Capital Plan for 23/24 agreed by the Board as part of the Annual Financial Plan, with outline plans for subsequent years included.	Establishing capital budgets and having clarity on the capital programme ensures that clear plan is in place to continue to modernise the estate with clear means of resourcing. The capital programme is monitored through use of the finance reporting to a number of groups/committees to ensure the Trust is well sighted on the capital programme and can manage this effectively. Capital resources have been provided through this budget for 23/24.
Managing working capital (cash) effectively	Monitoring of cash levels via finance report to ensure cash levels are sufficient to resource the capital plan.
Secure funding and authority to implement changes to Estate through the CEDAR programme. • OBC approval (including inherent improvement in revenue position) • Bridging Loan Secured • Business Case Addendum	Approval of the business case and associated funding provides the required resources to adequately fund the CEDAR programme. Treasury approval is still outstanding for the business case addendum, but NHP and NHSE approval has been secured.
CEDAR Programme Board established with key partners	Ongoing operation of the CEDAR board ensures governance is in place to manage key risks and provide oversight of the project. Reporting into the Board of Directors evidence this is operating effectively on an ongoing basis.

Action Number	Action Description	Last Action Update	Person	Target Date

			Responsible	
13545	Business case addendum for CEDAR to be approved by NHP/Treasury	This action has now been completed	Kevin Scollay	**Closed**
13546	Addendum has been submitted and the Trust is currently engaged in responding to questions from NHP (KS)	This action has now been completed	Kevin Scollay	**Closed**
14329	Work with ICS colleagues to identify a means of mitigating CDEL pressures across the ICS, including those within the Trust plan.	N/A new action	Kevin Scollay	**31.03.25**

Internal Audit 2023/2024					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2547**	**Version**	**2**	**Risk Appetite/Subcategory**	**Digital-Cyber Threats -** CNTW has a LOW appetite for risks which may compromise the Trust's digital infrastructure. 6-10 – **Data Security**
Next Review	**30/06/2024**						
Executive Lead	**Kevin Scollay**	**Lead Committee**	**Resource and Business Assurance Committee**			**Strategic Ambition**	**SA 4 – Sustainable for the long term, innovating every day**

Risk Description

Risk that the Trust's information and systems is at higher risk of being compromised leading to unknown vulnerabilities. This could lead to loss of, and/or public disclosure of, information and loss of access to critical systems.

Context of the risk (narrative & background) Gaps in Controls/Assurances

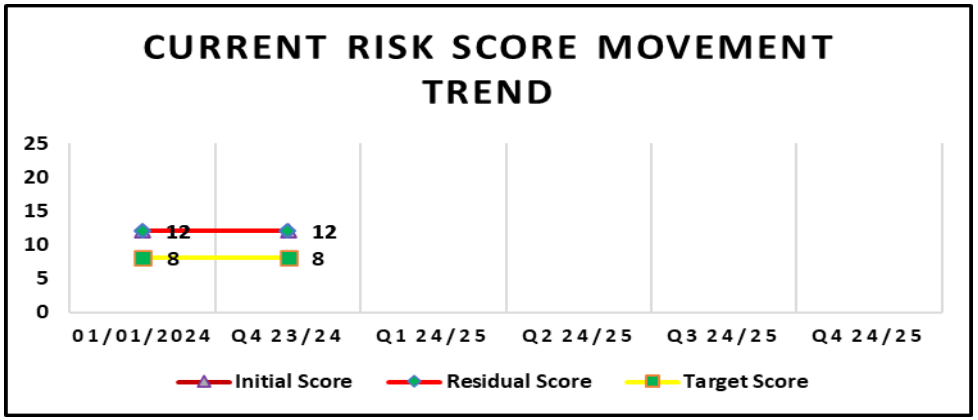
Due to a more adversarial geopolitical environment, including the ongoing war in Ukraine, the rise of state-aligned groups from around the globe, and an observed rise in more aggressive cyber activity, it is highly likely cyber threats to the UK health sector will increase.

The cybercrime threat to the UK health sector includes ransomware, phishing, commodity malware, data theft and extortion, cyber enabled fraud and Distributed Denial of Service, which are routinely seen across the sector. Of these threats, ransomware almost certainly remains the largest and most likely disruptive threat to the UK health sector, with cyber criminals taking advantage of the disruption caused to essential services for the purposes of extortion. It is likely cyber criminals view ransomware attacks against the health sector, especially hospitals and essential services, as particularly effective because of the time-critical nature of the services that can be disrupted.

Cyber-attacks represent a threat to the confidentiality, integrity, robustness and capability of digital systems and services, and their associated use:

- Access to electronic information prevented
- Ability to effectively treat patients compromised
- Timely capture of data prevented
- External information unavailable to fulfil contractual requirements
- Damage to reputation
- Significant financial costs
- Security Vulnerability

	Likelihood	Impact	Score	Score

				Residual Risk Score Movement Chart
Initial Score	3. Possible	4. Significant	**12**	
Residual Score	3. Possible	4. Significant	**12**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	**Summary of findings**				**Updated**
Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**No**		
	Actions Completed & Closed		**Yes actions 13547 & 13550 have been closed**		**28/03/2024**
	New Actions Added		**No**		
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**
Malware email filters in place on MS Office 365 to block known malicious content along with anti-virus protection on machines that is updated daily.	Evidence of blocked authentications can be shown via Office 365 reports.
MS Windows Enterprise facilities enabled such as AppLocker which blocks untrusted applications from running on end user devices	Blocked applications can be evidenced from event logs that are pulled centrally. Service desk calls are raised by staff to unblock any legitimate applications that are not already centrally approved

Trust managed laptops, PCs and servers are linked to NHS Data Security Centre MS Defender for End point service that continuously monitors devices for malicious behaviour	Emails are received from NHSE which provide evidence of number of systems communicating back to central service. Periodic emails raised with alerts from the centre that need further investigation.
External email configured with DMARC/DKIM sender authentication which blocks impersonation of emails from CNTW	Recently implemented to supplier best practice, due to be audited 23/24 via AuditOne.
Immutable backups for critical data such as EPR system have been setup.	Recently audited via AuditOne for the Data Security and Protection Toolkit.
Systems patched via monthly process including internet browser to limit risk against known exploits.	Copy of process in place.
Mandatory IG and Data Security training of staff to help promote identification of malicious emails and cyber security awareness.	IG and Data Security training levels are measured and tracked annually to meet data security and protection toolkit compliance.
Multi factor authentication of staff accessing Office 365 sensitive information which depends on the managed device they are using as well as any usernames and passwords that they know.	Evidence of blocked authentications can be shown via Office 365 reports.
Extra layers of authentication protection for privileged access to critical infrastructure which includes separate two factor authentication on data systems such as virtualisation platforms and critical network equipment.	External assessed annually via CIS benchmarking process needed for NHS Secure Email accreditation
Penetration tests carried out annually by CREST accredited independent auditors on Internet exposed services to help identify any potential exploitable systems.	CREST accredited report
Implementation has been externally assessed by AuditOne with a substantial assurance rating.	Report from AuditOne with a substantial assurance rating.

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13547	Upgrade Internet firewalls which provide additional capabilities such as blocking traffic based on country (GeoIP). Continue replacing Cisco ASA units with Cisco Firepower units.	Complete - Internet firewalls are now in and we have started to block traffic by country (GeoIP) This action can now be closed.	**Gillian Colquhoun**	**Closed**
13548	Start deploying Windows 11 operating system across the organisation on new machines which has additional security features. Testing carried out on Windows 11 with further work needed to review apps and devices that are capable of running the system.	The Windows 11 configuration and security work is still ongoing although it has been difficult to apportion much resource to it due to recent workloads. We aim to get this deployed during the Summer with a completion date of October 25 when Windows 10 goes end of support.	**Gillian Colquhoun**	**31.10.24**
13549	Recruit a new Cyber Security Analyst post for a dedicated resource to provide a more proactive	This is still being discussed internally together with considering options for a more	**Gillian Colquhoun**	**31.10.24**

	approach to on-going cyber threats. A job description has been prepared. Awaiting funding approval to proceed to recruitment.	central regional approach.		
13550	Clarify reporting arrangements for the provision of assurance relating to the management of cyber-risks.	It has been confirmed Digital with report formally via RBAC. Proposed ToRs have been agreed by RBAC. This action can now be closed	**Gillian Colquhoun**	**Closed**

Internal Audit 2023/2024					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Corporate Risk Register alignment to the Resource and Business Assurance Committee BAF risks

There are no high-level risks on the Corporate Risk Register (those scoring 16+) currently aligned to the Resource and Business Assurance Committee BAF risks.

3.3 BAF risks aligned to People Committee from Q4 2023/24

Date Opened	**01/01/2024**	**Risks Ref No:**	**2542**	**Version**	**2**	**Risk Appetite/Subcategory**	**Workforce/Staffing** - CNTW has a LOW appetite for risks associated with the Trust's workforce supply, skills and capacity and wellbeing within an appropriate culture (6-10) – **Staffing**
Next Review	**30/06/2024**						
Executive Lead	**Lynne Shaw**	**Lead Committee**	**People Committee**			**Strategic Ambition**	**SA 3 – A great place to work**

Risk Description

Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3

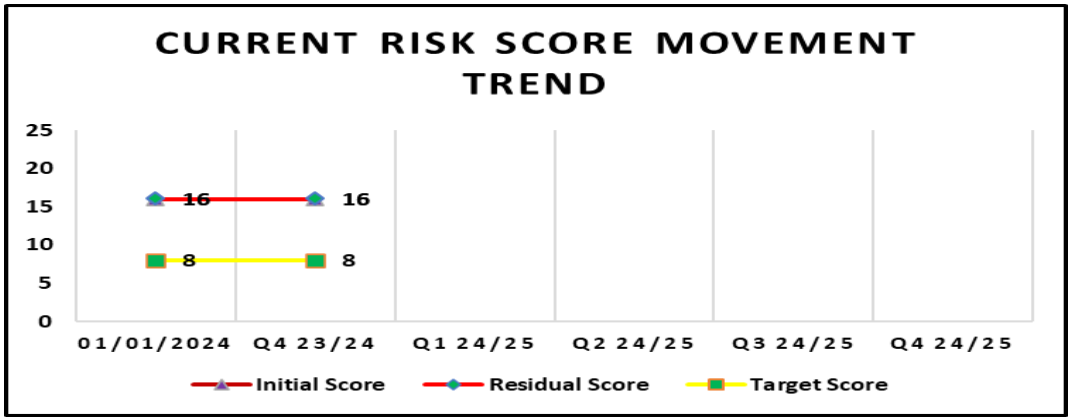
Context of the risk (narrative & background) Gaps in Controls/Assurances

To provide safe services and appropriate therapeutic interventions it is important to ensure that the workforce model across the Trust is fit for purpose with staff in the right numbers and with the right skills.
It is imperative that a sustainable workforce plan is in place to reduce the risks to providing safe, high-quality care. This includes ensuring staff have the required skills, competencies, and training to undertake their roles. A sustainable workforce plan also needs to include plans to achieve our Strategic objectives aligned to the commitments to our workforce in relation to personal and professional development. Gaps in Controls/Assurances include: -

- Absence of a sustainable workforce plan.
- Establishment control to ensure accurate recording and reporting of vacancies.
- Current workforce skills are not currently recorded and mapped against post requirements.
- Skills gaps are not identified, and adequate training put in place to address the shortfalls.
- Inclusive recruitment work has had an impact on increasing the BAME workforce but predominantly this is in lower banded posts.
- Strengthening of internal process for accessing development monies required.
- Release of staff to undertake relevant training and development opportunities is currently a challenge.
- Lack of joined up approach between appraisals and training requirements.
- Challenges ensuring the temporary workforce maintain the required skills.
- More robust recording and reporting mechanisms is required to enable leadership and management development and succession planning.

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart

Initial Score	4. Likely	4. Significant	**16**
Residual Score	4. Likely	4. Significant	**16**
Target Score	2. Unlikely	4. Significant	**8**



Key questions:	**Summary of findings**				**Updated**
Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**Yes**		**31/03/2024**
	Actions Completed & Closed		**Yes actions 13527 & 13528 have been closed**		**31/03/2024**
	New Actions Added		**Yes actions 14286, 14267 & 14288 have been added**		**31/03/2024**
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	**How do we know what we have in place is making an impact (assurance and evidence)**
A training needs analysis outlining training requirements for statutory and essential training is in place for all professions/service areas.	Staff are trained to the required standard in terms of statutory and essential training as identified by Skills for Health or internal determination. Sufficient training places are in place annually for face to face programmes.
CPD and Workforce Development Monies is ring-fenced for the development of medical/non-medical staff.	NHSE Returns identify monies spent and on which training topics.
Leadership and management skills are in place across the Trust to support succession planning.	Staff survey responses to Manager/Leadership/career development questions. Reduction in employee relations issues (incl., grievances and disciplinaries).

	Reduction in incidents.
International recruitment programme for medical, nursing and allied health professionals	International recruitment and the GMC Fellowship scheme has increased the supply of doctors working across the Trust. Nursing and AHP Numbers have improved over recent years (though currently there is a pause in recruitment of the non-medical workforce)
Apprenticeship model in place with 2-, 3-, 4- and 5-year schemes.	Increase in the number of nurses coming through the Trust because of the CNTW Academy 'grow your own' approach.
Various schemes in place with local colleges to support the widening participation agenda.	CNTW Academy data. Workforce data.
Statutory and Mandatory training requirements (10 core subjects) are in place as part of induction.	Corporate Induction is mandatory therefore all staff will have completed the 10 core areas prior to or at the Trust Induction.
Final Internal Audit Report - CNTW 2023-24 04 Pre Employment Checks	Substantial assurance that compliance with the control framework was found to be taking place; any non-compliance identified was addressed by the Trust at the time of the audit.

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13524	Community transformation work on the clinical model to be completed	This action is still ongoing and could take several months to complete	**Rajesh Nadkarni**	**31.03.25**
13527	Development of support worker programme	Closed	**Gemma Rutherford**	**Closed**
13526	Introduce a robust establishment control process.	This is linked to the rollout of ESR which is a longer term project.	**Gemma Rutherford**	**31.03.25**
13525	Introduce comprehensive induction programme for unregistered staff	Action updated. Induction programme in development and initial draft discussed at BDGW. Roll out plan being developed.	**Vida Morris**	**30.06.24**
13258	Training Needs Analysis to be reviewed	Closed	**Gemma Rutherford**	**Closed**
13529	Recording of skills on ESR	This is longer term project linked to the ESR project	**Gemma Rutherford**	**31.03.25**
14286	Edward Jenner Programme to be introduced for all new starters with no leadership qualifications	N/A new action	**Emma Lovell**	**30.06.24**
14287	Support Worker Development Programme to be rolled out	N/A new action	**Emma Lovell**	**30.06.24**
14288	Workforce plan to be produced	N/A new action	**Gemma Rutherford**	**31.03.25**

Internal Audit 2023/2024					
People Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
People Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2544**	**Version**	**2**	**Risk Appetite/Subcategory**	**Workforce/Staffing -** CNTW has a **LOW** appetite for risks associated with the Trust's workforce supply, skills and capacity and wellbeing within an appropriate culture. 6-10 **Staffing**
Next Review	**30/06/2024**						
Executive Lead	**Lynne Shaw**	**Lead Committee**	**People Committee**			**Strategic Ambition**	**SA 3 – A great place to work**

Risk Description

Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up. SA3

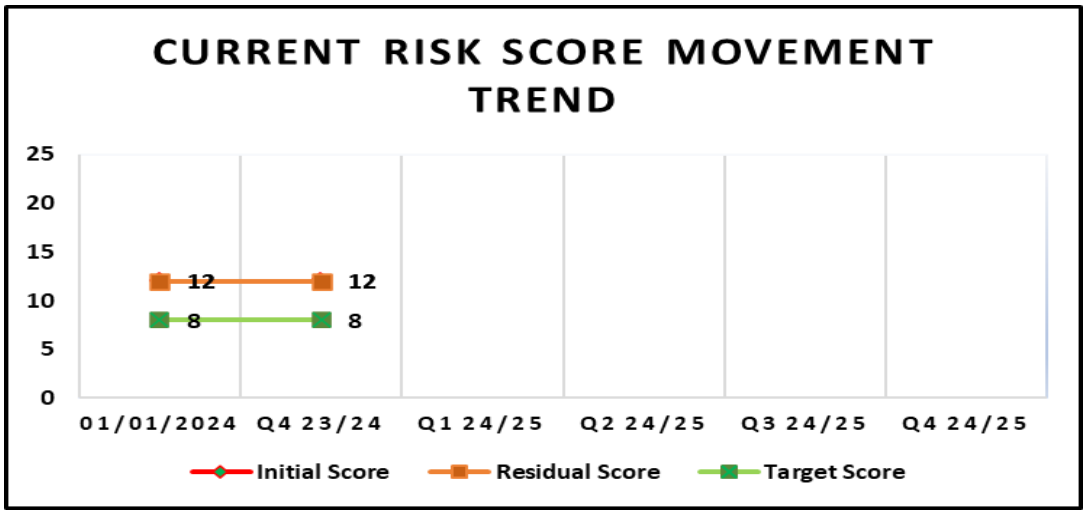
Context of the risk (narrative & background) Gaps in Controls/Assurances

The Trust aims to be a great place to work. Poor culture will have a significant impact on the attraction, recruitment, and retention of staff. It is important that there is adequate support in place for health and wellbeing and inclusion. Flexible working and work/life balance is important to staff as is a sense of belonging. This is measured in the staff survey and quarterly staff People Pulse survey, so it is able to be monitored regularly.

Creating a compassionate just and learning culture will have an impact on staff wellbeing, patient safety, a sense of psychological safety which will in turn reduce sickness absence, turnover, investigations.

It is important that staff have the confidence to raise concerns to ensure that patient and staff safety is maintained. Some staff are reluctant to raise concerns as they fear retribution and/or feel that nothing is done with the issues raised. Gaps in Controls/Assurances include: -

- Flexible working is not monitored or easily reportable
- Full implementation of PSIRF
- Further work required on the development and implementation of compassionate, just and learning culture

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart
Initial Score	3. Possible	4. Significant	**12**	
Residual Score	3. Possible	4. Significant	**12**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	Summary of findings				Updated
Have there been any changes to risk?	**Description**		**No**		
	Owner		**No**		
	Residual Score		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**No**		
	Actions Completed & Closed		**No**		
	New Actions Added		**Yes actions 14289, 14290, 14291 & 14292 have been added**		
Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
Regular monitoring of People Metrics e.g., - Turnover	Feedback/reports of improvements in People Metrics discussed at BDGW and People Committee.

- sickness absence - reasons for absence - morale and motivation - investigations - Freedom to Speak up concerns	
Occupational Health service and monthly contract review	Monthly contract review meetings
Staff Psychological Service	Annual report to People Committee
Review point meetings for absence	Not centrally monitored – absence management is devolved to Groups
Reasonable Adjustments process in place with central budget	Process in place held in central budget - not monitored in terms of impact
Staff Networks with identified Chairs (Exec sponsors for each network)	Network Chairs appointed through expressions of interest. Exec Sponsors for each Network.
Freedom to Speak up Guardians (FTSU) have regular contact with Trust Board members (including names NED) and have high visibility across the Trust	Monthly FTSU monitoring through BDG-Workforce, bi-annual reporting through People Committee and Trust Board. FTSU Guardians attendance at People Committee bi-annually. Monthly Meetings with Executive Director of Workforce and OD and six weekly meetings with NED. FTSU Guardians have 19.5 hours per week time allocated to FTSU duties. Posters in all wards/departments. FTSU page on intranet.
Thrive Website	Access to the website via Intranet
Health and Wellbeing approach (STAR)	Update on activity discussed at the People Committee bi-annually
Supportive workforce policies in place	Copy of policy and staff aware of where to access the policy

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13536	More information to be stored in ESR.	Continuation of the ESR project plan, monitored via ESR project board	**Gemma Rutherford**	**31.10.24**
13537	Management Skills Programme to be rolled out across the Trust.	Action updated to reflect up to date position and action owner amended	**Marc House**	**31.04.25**
13538	Improve Employee Relations processes supported by just culture principles and implement a Resolution policy.	Action updated to make more relevant and action owner updated. action target date updated.	**Lynn Shaw**	**30.06.24**
13539	Put in measures to address key Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators: -Reduce discrimination bullying and harassment -Improve progression for BAME Staff	Action updated to reflect current position, action owner updated and action date updated	**Christopher Rowlands**	**30.09.24**
14289	Refresh Freedom to Speak up approach including development of Champion roles	N/A new action	**Lynn Shaw**	**30.09.24**
14290	Improve uptake of health and wellbeing conversations	N/A new action	**Ramona Duguid**	**31.12.24**

14291	Review appraisal process in line with you in mind ensuring staff have clarity around roles, responsibilities and objectives	N/A new action	**Kim Carter**	**30.09.24**
14292	Develop coaching/mentoring offer for staff	N/A new action	**Emma Lovell**	**30.06.24**

Internal Audit 2023/2024					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Corporate Risk Register alignment to the BAF – People Committee

Although there are no high-level risks on the Corporate Risk Register (those scoring 16+) currently aligned to the People Committee BAF risks, it should be noted that there are currently 40 staffing risks on the live risk register across the organisation which are being managed at directorate, care group, or ward/CBU level. Following a discussion at Business Delivery Group-Risk at the meeting held 23 April, it is proposed that a collective discussion on these risks be held at a future meeting to discuss, reporting, scoring and management of such risks.

The Corporate Risk Register does hold a risk relating to Violence and Aggression as follows. Although this risk is aligned to the Quality and Performance Committee, it was felt prudent to ensure People Committee are also sighted on this risk in the context of the recent Health and Safety Executive Improvement Notice issued to the Trust, as well as the outstanding actions in relation to impact on staff wellbeing.

Corporate Risk Register No clear alignment to BAF risks		
Ward/Department Risk 2624	**Residual Score 16**	
Due to the presentation of some patients who are admitted to the ward, there is a risk of violence and aggression to staff and/or patients, which could result in serious harm. Currently there is an increased risk of racial abuse and physical abuse towards staff which will impact staffs wellbeing and safety as well as patients safety.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
• Police liaison to visit patients on wards for educational purposes • Training to be provided to all staff 'hate crime training' • Regular team meetings to discuss staff wellbeing		

3.4 New BAF risks aligned to the Board from Q4 2023/24

Date Opened	**01/01/2024**	**Risks Ref No:**	**2548**	**Version**	**2**	**Risk Appetite/Subcategory**	**Partnership Working -** CNTW has a HIGH appetite for risks associated with working in partnership and collaboration across the NENC system which may support and benefit the people we serve. 16-25 **Other**
Next Review	**30/06/2024**						
Executive Lead	**James Duncan**	**Lead Committee**	**Board of Directors**			**Strategic Ambition**	**SA 5 – Working with, and for, our communities**

Risk Description

If the Trust does not consider its own position as a 'good partner', and the position of others as capable of working in partnership, there is a risk of that the Trust and the system does not allocate resource effectively, in the right place with the right organisations and partnerships which may impact on the ability to deliver high quality, safe services across the system.

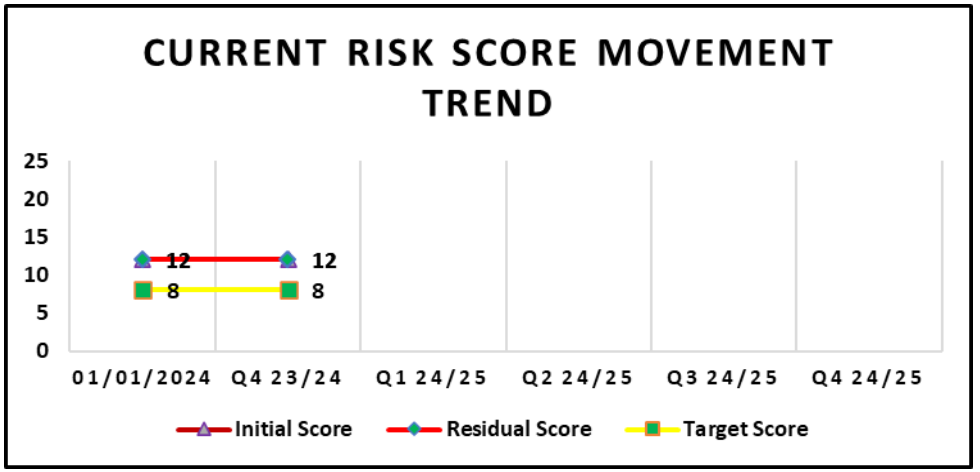
Context of the risk (narrative & background) Gaps in Controls/Assurances

The Trust continues to work as a trusted system partner in the NENC ICS and place-based partnerships and arrangements. The Executive Team have established excellent working relationships with the Integrated Care Board and have in place, where appropriate, leadership roles for ICS-level programmes of work / workstreams.

The ICS/ICB have a responsibility to develop their own strategic ambitions and priorities and it is important that this includes the strategic ambitions of the Trust. This is particularly in the context of:
- Ensuring parity of esteem for MHLDA services across the footprint
- Recognition that the Trust's strategic objectives cannot be achieved as a single organisation.
- The priorities for the ICB and other providers across the system including the impact of the pandemic on service demand in all areas (including acute, ambulance and other health and care providers).
- Recognition that the Trust's priorities in terms of its transformation plans reflect system-wide issues.

Gaps in Controls/Assurances include: -

- Challenges relating to the Trust's geographic footprint and aligning this to current locality structures in terms of capacity to be present and influence system discussions.
- Ensuring the Trust has a consistent narrative across all localities in terms of priorities and influence.
- Complex governance structure at ICS level and assurance in terms of the voice of MHLDA at all levels.

	Likelihood	Impact	Score	Score Residual Risk Score Movement Chart
Initial Score	3. Possible	4. Significant	**12**	
Residual Score	3. Possible	4. Significant	**12**	
Target Score	2. Unlikely	4. Significant	**8**	

Key questions:	Summary of findings		Updated
Have there been any changes to risk?	**Description**	**No**	
	Owner	**No**	
	Residual Score	**No**	
	Is risk to be closed	**No**	
Have actions progressed?	**Control and Assurances added.**	**No**	
	Actions Completed & Closed	**No**	
	New Actions Added	**No**	

Do all actions have a timescale?	**Yes**	**Were risks reviewed in a timely manner?**	**Yes**	**Expected date risk to be mitigated and brought within the risk category appetite.**	**2024/25**

What are we already doing to manage the risk (controls already in place)	How do we know what we have in place is making an impact (assurance and evidence)
Trust representation on the NENC ICB Board of Directors	Positive outcome following CNTW/NENC ICB accountability meetings.
Executive Leads identified for core work programmes / workstreams	Increased involvement of the Trust in place-based activity and work
Named individuals at Locality level representing the Trust at Place.	EMG minutes

Strong relationships with third sector organisations.	Minutes Provider Collaborative Committee meeting demonstrate shared approaches to prioritisation of plans and decision-making from a system perspective.

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
13551	Development of a formal written report to the Board providing assurance of ICS/ICB working.	This report is still in development stages**.**	**Debbie Henderson**	**30.06.24**
13552	Review of Provider Collaborative governance arrangements including roles as responsibilities (providers, lead providers, commissioners).	Review of Provider Collaborative is still ongoing.	**Kevin Scollay**	**30.06.24**

Internal Audit 2023/2024					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q4					

Clinical Audit Plan					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q4					

Corporate Risk Register alignment to the Board – Board-level risks

There are no high-level risks on the Corporate Risk Register (those scoring 16+) currently aligned to the Board BAF risk.

4.0 Corporate Risk Register risks (high-level risks 16+)

The following remaining risks on the Corporate Risk Register are considered to be amongst the highest-level risks across the organisation. These risks are not aligned to any specific BAF risks, but represent risks in their own right, being managed at Executive level.

Corporate Risk Register - 2439 **No clear alignment to BAF risks**		
Ward/Department Risk 2439	**Residual Score 16**	
South Tyneside Learning Disabilities Community Treatment provision is provided using an alliance approach between STSFT and CNTW for health care. Both organisations have their own clinical and operational policies and procedures and electronic record keeping systems. There is a risk that service user's care and treatment and cohesive MDT ways of working could be compromised due to the alliance approach. This is likely to happen with a major impact on services.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
• Upcoming potential TUPE.		

Risk 2439 was discussed at the Executive Management Meeting held 22 April and it was agreed that once the full mitigations relating to TUPE are implemented, the risk would be de-escalated. This will be reflected in the Q1 2024/25 report.

Corporate Risk Register - 2624 **No clear alignment to BAF risks**		
Ward/Department Risk 2624	**Residual Score 16**	
Due to the presentation of some patients who are admitted to the ward, there is a risk of violence and aggression to staff and/or patients, which could result in serious harm. Currently there is an increased risk of racial abuse and physical abuse towards staff which will impact staffs wellbeing and safety as well as patients safety.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		

At the Executive Management Group meeting held 22 April, a discussion and sense-check took place on the Corporate Risk Register and what was perceived as the highest-level risks in the organisation (excluding the Board Assurance Framework risks). It was noted that there were potential gaps in relation to the following:

- Waiting times
- Access to Crisis Services
- Financial planning and delivery

It is proposed that these risks be considered during the next quarter with any additions to the Corporate Risk Register being reflected in the quarter 1 2024/25 report.

A copy of the full Corporate Risk Register is provided in Appendix A.

5.0 Outstanding actions and next steps

5.1 Risk Management Policy

The new Risk Management Policy went live on 6 March 2024. The policy provides detail on:

- What risk is, how we spot risks, and how we describe and assess them clearly.
- How risks are managed by helping people look at what measures are in place to reduce the risk occurring, assurance that the controls are working, and what more we need to do.
- The different types of risk registers used in the organisation, where these are discussed, and who has responsibility for making sure they're being managed well.
- How people can escalate risks and get support and advice when risks become so concerning, they can no longer be managed at a local level.

5.2 Risk Management Policy – Changes to definitions and escalation process

Risk Owners

The risk management process specifies risks which need to be actively managed. These are assigned a risk owner who is accountable for owning and reporting on the risk and overseeing the development and maintenance of appropriate controls and mitigation. While the risk owner has overall accountability for the management of the risk, they might not own or operate the control(s) which relates to the risk. In this case, the role of the risk owner is to oversee that the control(s) are owned, are fit for purpose, and operate effectively and that identified actions are implemented by the action owners.

Risk Handler

A risk handler is the person with responsibility for the day-to-day management of the specific risk assigned. If a risk is escalated the **original owner** of the risk becomes **the handler** who will manage the risk until it is deescalated back to them., The person the risk was escalated to becomes the new owner and will be accountable for the overall management of the risk.

Action Owners

Risk owners may not be able to take all the necessary actions to mitigate a risk. Action owners are nominated individuals with responsibility for taking the required actions. An individual risk may have several identified actions – and each of these may have a different action owner.

Escalation, de-escalation and archiving of risks as appropriate

The consequences of some risks, or the action needed to mitigate them, can require escalation of the risk to a higher management level. For example, from a ward to a Clinical Business Unit/Speciality risk register. Risks will be escalated and de-escalated within the defined appetite for each level. The risk owner should discuss and seek approval from their manager for escalation and de-escalation consideration.

5.2 E-Learning Package for Web Risk Training

In line with the review of the Risk Management Policy and clarity regarding escalation and management of risks in the organisation, an e-learning training package for all staff with

responsibility for managing and reporting risks went live on 18 March 2024. Risk Management Lead has contacted the Academy requesting the e-learning package become mandatory at Local Induction Training for members of staff new to NTW Solutions and CNTW Band 7 and above where holding a risk register is an integral part of their roll and a required competency. The training will also be mandatory for staff promoted into a Band 7 and above role where holding a risk register is an integral part of their role and a required competency.

Risk lead has also requested the training be aligned to performance dashboards for reporting and assurance purposes.

5.3 Updates to Web Risk System

As the date for the new structure is fast approaching the Project Team are currently making the changes to Trust hierarchy as this effects Risk and Group Security. They are also updating all security settings in line with the new escalation process in the new Risk Policy. This is a very complex process and the project team are working extremely hard along with the Risk Lead to ensure the changes are made with as little distribution to users as possible. Work has been scheduled to take place on 15 April 2024 in line with the new structure.

5.4 Internal Audit – Risk Management and Board Assurance Framework

In accordance with the operational internal audit plan for 2023/24, an audit of the Risk Management and Board Assurance Framework (BAF) processes was approved by the Audit Committee. This audit underpins the annual Head of Internal Audit Opinion and the Trust's Annual Governance Statement. The Annual Internal Audit Opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The annual work undertaken around BAF and risk management was reflected on in preparing the scope review. This entailed a review of commonly reported issues in audit work across the sector, and in CQC and Well Led reports. This annual review was structured to build on previous work and to specifically target those areas of reported weakness.

The review found that governance, risk management and control arrangements in the Trust provided **substantial assurance** that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.

This represents a significant achievement in the context of the substantial review and changes to the Trust's Board Assurance Framework and Risk Management Policy and processes during the period.

Summary discussion from the Board Committees held April/May 2024

A discussion took place at People Committee, Quality and Performance Committee, and Resource and Business Assurance Committee regarding the ongoing appropriateness of the risks, risk descriptors, mitigations and actions.

It was recognised that the new Board Assurance Framework was providing an important vehicle for Committees to sense-check and seek assurance that agendas, planning, discussions, and areas of focus were relevant and linked to the key issues facing the Trust.

It was agreed that a review of the risks and descriptors be undertaken during Q1 for each of the BAF risks with this learning in mind to ensure the value of the BAF in terms of informing focus remains in place, and indeed improves over time.

6.0 Recommendation

The Board is asked to:

- Discuss the content of the report and:
  - Gain assurance that the BAF risks are being managed effectively.
  - Review the Corporate Risk Register high-level risks in section 4 and alignment to the BAF, seeking further assurance on the high-level risks (16+) and information thereon.

Executive Lead: Sarah Rushbrooke, Executive Director of Nursing, Therapies, Quality and Assurance
Lead Officer: Debbie Henderson, Director of Communications and Corporate Affairs
Date: 20 May 2024

Risk Appetite Statement

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) recognises that its long-term sustainability depends upon the delivery of its strategic ambitions. CNTW will not accept risks that materially provide an adverse impact on quality, safety, experience, and effectiveness.

However, CNTW has a greater appetite to take considered risks in terms of partnership working, and collaboration on organisational and system issues, and clinical innovation, in terms of its willingness to take opportunities where positive gains can be anticipated and/or it is in the best interests of the population we serve.

Category	Risk Appetite	Risk Appetite Score
Quality (effectiveness and experience)	CNTW has a **LOW** appetite for risks that may compromise the delivery of outcomes, or risks that may affect the experience of, our service users.	**6-10**
Quality (safety)	CNTW has a **LOW** appetite for risks that may compromise safety.	**6-10**
Statutory and regulatory compliance	CNTW has a **LOW** appetite for risks which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**
Financial	CNTW has a **LOW** appetite for risks that impact on the possibility of financial loss and our ability to deliver care and treatment in the longer-term.	**6-10**
Digital – Cyber threats	CNTW has a **LOW** appetite for risks which may compromise the Trust's digital infrastructure.	**6-10**
Workforce/staffing	CNTW has a **LOW** appetite for risks associated with the Trust's workforce supply, skills and capacity and wellbeing within an appropriate culture.	**6-10**
Model of care	CNTW has a **MODERATE** appetite for risks associated with the development of the organisations model of care that does not compromise quality of care.	**12-15**
Estate infrastructure	CNTW has a **MODERATE** risk appetite for poor estates and infrastructure that may impact on our ability to deliver care in a safe environment.	**12-15**
Climate and Ecological Sustainability	CNTW has a **MODERATE** appetite for risks that may result in the harming of the environment which could lead to affect the physical and mental health of the populations we serve.	**12-15**
Innovation	CNTW has a **MODERATE** appetite for risks associated with clinical, non-clinical and digital innovation that does not compromise quality of care.	**12-15**
Partnership working	CNTW has a **HIGH** appetite for risks associated with working in partnership and collaboration across the NENC system which may support and benefit the people we serve.	**16-25**

IMPACT score x LIKELIHOOD score = RISK score

	IMPACT				
LIKELIHOOD	**1. Negligible**	**2. Minor**	**3. Moderate**	**4. Significant**	**5.Major**
1 – Rare Not expected to occur	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2 – Unlikely Occurs infrequently	2 Very Low	4 Very Low	6 Low	8 Low	10 Low
3 – Possible Once or twice a year	3 Very Low	6 Low	9 Low	12 Moderate	15 Moderate
4 – Likely Hazard will occur but is not persistent.	4 Very Low	8 Low	12 Moderate	16 High	20 High
5 –Almost Certain Constant threat is custom and practice	5 Very Low	10 Low	15 Moderate	20 High	25 High

Inpatient Care Group

North Inpatients CBU

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	**Risk Rating:**	**Likelihood**	**Impact**	**Score**	**Rating**
Non-Compliance with Discharge Summaries being sent to GP within 24 hours of patient discharge. RiO including Medication pages are not being kept up to date as per CNTW policy. Information transferred to the Mental Health Discharge Summary may not be accurate. Source of the Risk: Internal audit NTW16/17/07 - assurance audit of medication summary and discharge letter.	Risk on identification (19/01/2014):	4	4	16	High (Red)
	Residual Risk (with current controls in place):	4	4	16	High (Red)
	Target Risk (after improved controls):	1	4	4	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Quality Safety (6-10)			Breach
	Risk Appetite Subcategory	Quality Safety - Data Quality			
	Who is potentially at Risk?	Patient			

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence (how do we know we are making an impact)**	**Gaps in Controls (Further actions to achieve target risk)**
1 Record keeping standards MR PGN 02	1 Relevant staff are aware of the Record Keeping Standards PGN and where to access it.	Internal Audit of Medication Summaries and Discharge Summaries to commence in Q1 2024/25
2 Internal audit NTW16/17/07 - assurance audit of medication summary and discharge letter.	2 Assurance report December 2016 (limited assurance)	Improve compliance with the Discharge Summary being sent to GP's within 24hrs of the discharge date.
3 CA-198-0032: Medication Summaries and Discharge Letters Audit (Clinical Audit Report) 6th October 2020 Overall Outcome - Areas of Concern	3 Process in place for ongoing monitoring of Audit Action Plan at CBU Quality Standards meetings	Locality Attendance of medic at the Trustwide Discharge Summaries Meeting
4 Electronic Prescribing on all North Locality Wards	4 EMPA system in place. In the discharge process, the active medications on the electronic system is transferred across to discharge letters. Then	

			awaiting a consultant/senior medic sign off for the release of the discharge letter to the GP.	
2	Group Directors have appointed an Associate Medical Director champion to promote compliance in the Locality.	2	The Associate Medical Director receives compliance data which is shared within the CBU Quality Standards meeting to promote compliance. The minutes of the meeting are taken to evidence the discussion and actions.	
3	Discharge Summary Process is in place	3	Relevant staff are aware of the current Discharge Summary Process	
4	Internal Audit ca-22-079 Medication Summaries and Discharge Letters	4	Audit findings have been shared with relevant staff. Staff are aware of the areas of improved compliance and areas requiring improvement.	

Ref: 1287v.62

Risk Owner: Rajesh Nadkarni

Next Review Date: 16/07/2024

Review/Comments:

17/04/2024 - Yvonne Newby - In line with new risk management policy this risk will be escalated to CRR 16+ risk register. Jonathon will become the handler of the risk and carry out day to day management, Dr Rajesh Nadkarni will be the new owner of the risk until risk is mitigated and de escalated.

Inpatient Care Group

Central Inpatients CBU

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	**Risk Rating:**	**Likelihood**	**Impact**	**Score**	**Rating**
Due to increasing levels of criminal activity, there is a significant risk of interruption of power, water and heating systems being lost to all in-patient areas on the CAV site. This could lead to prolonged periods of outages leading to patient safety and wellbeing issues. This site belongs to Newcastle University with responsibility for mains infrastructure being held by NUTH - with Solutions on responsible for internal building maintenance. There are therefore complex security and estates issues when dealing with this criminal activity. The site is also served via the water services infrastructure which formerly served the wider NGH site. It is therefore significantly oversized for its current demand. Due to this consistent levels of microbiological activity/Legionella are recorded during routine water sampling. As usage further reduces due to services vacating the site these issues will be exacerbated.	Risk on identification (22/06/2023):	5	4	20	High (Red)
	Residual Risk (with current controls in place):	5	4	20	High (Red)
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Safety (6-10)			Breach
	Risk Appetite Subcategory	Quality Safety - Environmental			
	Who is potentially at Risk?	Patient & Staff			

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence (how do we know we are making an impact)**	**Gaps in Controls (Further actions to achieve target risk)**
1 Regular meetings with NUTH and Newcastle University (fortnightly)	1 Notes of meetings.	ML meeting Associate Director Estates for NUTH on 23/6/23 to discuss estates infrastructure issues and possible mitigative actions.

1	Newcastle University have put additional patrols to building perimeters and internally.	1	Newcastle University agreed to and instigate additional patrols to building perimeters and internally.	NuTH are arranging a meeting with Head of Security at Uni to urgently discuss options. Have requested we are linked in
2	RVI in house security are increasing drive by patrols to site	2	Log books	NuTH Estates are looking at options to restrict vehicle access to the bottom end of the site i.e. main gates
3	Additional flushing and testing regimes have been introduced to increase movement and usage. Significant and ongoing works have been undertaken via NTW Solutions working in collaboration with NuTH to locally address each failure.	3	NTW Solutions working in collaboration with NuTH to locally address each failure. Records of works planned and carried out.	Installation of replacement water tanks and distribution mains along with Chlorine Dioxide dosing plant. This will require significant investment.
4	Regular and ongoing meetings in place with NTWS, CNTW (IPC), NuTH Estates and IPC are in place also including external independent Authorising Engineers input to manage the position.	4	Minutes from meetings with NTWS, CNTW (IPC), NuTH Estates and IPC are available.	
5	Increased security activity has been initiated	5	Head of Facilities is monitoring progress of site activity Nuth	

Ref: 2431v.12

Risk Owner: Ramona Duguid

Next Review Date: 28/06/2024

Review/Comments:

18/04/2024 - Yvonne Newby - Risk reviewed. Actions updated and new target dates set. Residual score remains the same at this review due to ongoing actions.

Community Care Group

Sunderland & South Tyneside Place Team

Community Learning Disabilities

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
South Tyneside Learning Disabilities Community Treatment provision is provided using an alliance approach between STSFT and CNTW for health care. Both organisations have their own clinical and operational policies and procedures and electronic record keeping systems. There is a risk that service user's care and treatment and cohesive MDT ways of working could be compromised due to the alliance approach. This is likely to happen with a major impact on services.	Risk on identification (04/07/2023):	4	4	16	High (Red)
	Residual Risk (with current controls in place):	4	4	16	High (Red)
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Safety (6-10)			Breach
	Risk Appetite Subcategory	Quality Safety - Standards			
	Who is potentially at Risk?	Patient			

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Proactive, positive and transparent working relationship between both organisations senior management teams.	1 Alliance joint meeting minutes	Weekly interface meetings are now taking place to look at processes and systems across the two services. To keep under review.
2 Respectful working relationships between clinicians from both organisations.	2 Operational guidance document	Upcoming potential TUPE.
3 A shared vision for service delivery.	3 Operational guidance document	
4 Some shared clinical processes.	4 Operational guidance document	
5 Infrastructure for shared record keeping.	5 Information sharing protocol	
6 Oversight and support from placed based commissioning.	6 Alliance joint meeting minutes	
7 Regular interface meetings.	7 Minute from interface meetings available	
1 Monthly CM and MM meetings with shared action log for locality service shared between CNTW and STSFT.	1 Action Log	

Ref: 2439v.9

Risk Owner: Sarah Rushbrooke

Next Review Date: 11/07/2024

Review/Comments:

Inpatient Care Group

North Cumbria Inpatients CBU

Adult Acute Wards

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the location of Yewdale it is difficult to recruit staff to work there and it is isolated from the main hospital site (Carleton Clinic). Because of these factors there is an ongoing risk safer staffing levels will not be met and/or that the staffing compliment will not contain the MDT skill mix required to consistently provide safe and effective patient care. This is likely to happen and could have a major impact on patient care.	Risk on identification (23/08/2023):	5	4	20	High (Red)
	Residual Risk (with current controls in place):	4	4	16	High (Red)
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Safety (6-10)			Breach
	Risk Appetite Subcategory	Quality Safety - Staffing			
	Who is potentially at Risk?	Patient			

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Staffing shifts discussed daily within inpatient sitrep	1 meeting minutes	Ongoing discussions with the execs and ICB re: future of the ward and provision of care in West Cumbria
2 Cover for individual shifts is provided by other inpatient services where possible, this agreed as part of the daily sitrep	2 meeting minutes	
3 The 136 suite has been temporarily closed in order to free up staff to remain on the ward to work there.	3 Communications from Group Director.	
4 Yewdale continues to be supported by use of agency staff to make up numbers, however this is not a long term or sustainable solution.	4 Agency bookings and associated invoices.	
5 Inpatient CBU Management Team providing a daily presence on the ward to provide leadership. This is a mixture of input from Associate Director, Matron and Clinical Manager.	5 Outlook diaries.	

Ref: 2463v.21

Risk Owner: Ramona Duguid

Next Review Date: 26/04/2024

Review/Comments:

Specialist Care Group

Autism Inpatient Services CBU

Autism Wards

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the current ICB funding arrangements, Health and Safety Executive concerns, Clinical Ready for Discharge position and levels of Violence and Aggression experienced with Mitford, the Trust is currently unable to provide a speciality autism inpatient service and has been closed to new admissions. It is likely that patients might be put at risk of not receiving appropriate care and their treatment being delayed having a detrimental effect on their mental health. This could have a major impact on patients resulting in their care needs being met in an alternative environment which may not meet their needs as effectively. It would also have a financial impact as it would be more costly to meet care needs (inappropriate wards would need a greater package of care or out of area placement) The Clinical Model is currently undergoing a review.	Risk on identification (02/10/2023):	4	4	16	High (Red)
	Residual Risk (with current controls in place):	4	4	16	High (Red)
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Financial (6-10)			Breach
	Risk Appetite Subcategory	Financial - Commissioning			
	Who is potentially at Risk?	Not Applicable			

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Group Director Tracking and monitoring	1 Monthly reporting on current position to BDG Finance	Executive Director of Finance ongoing meetings with ICB Director if Finance to agree a resolution.
2 Monthly monitoring via Locality Assurance meetings - Operational Management Group	2 Discussed monthly in meetings. Monthly finance update and minutes of meetings	
1 Monthly CBU Finance meetings to monitor resources, staffing against budget	1 Discussed in meetings. Agenda and meeting minutes. Monthly finance report for each CBU.	

Ref: 2481v.12

Risk Owner: Ramona Duguid

Next Review Date: 10/05/2024

Review/Comments:

Community Care Group

Newcastle & Gateshead Place Team

Management

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
A number of GP practices have made the decision to withdraw from shared care arrangements.	Risk on identification (01/11/2023):	5	4	20	High (Red)
	Residual Risk (with current controls in place):	5	4	20	High (Red)
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Safety (6-10)			Breach
	Risk Appetite Subcategory	Quality Safety - Patient Safety			
	Who is potentially at Risk?	Patient			

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Ongoing discussion with ICB and GP surgeries. Meetings to be scheduled with Acute Trust to discuss as this affects them also.	1 Monthly place based ICB meetings and quarterly LMC meetings. It has been escalated to LDA Mental Health Board by Ramona Duguid. ICB oversight	Rajesh Nadkarni to escalate the issue around shared care arrangements with Neil O'Brien ICB. Kate (PCN)

Ref: 2508v.5

Risk Owner: Rajesh Nadkarni

Next Review Date: 28/06/2024

Review/Comments:

Inpatient Care Group

South Inpatients CBU

Learning Disabilities

Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the presentation of some patients who are admitted to the ward, there is a risk of violence and aggression to staff and/or patients, which could result in serious harm. Currently there is an increased risk of racial abuse and physical abuse towards staff which will impact staffs wellbeing and safety as well as patients safety.	Risk on identification (18/03/2024):	5	4	20	High (Red)
	Residual Risk (with current controls in place):	4	4	16	High (Red)
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Safety (6-10)			Breach
	Risk Appetite Subcategory	Quality Safety - Violence & Aggression			
	Who is potentially at Risk?	Patient & Staff			

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Debrief rota now in place including senior leadership.	1 Debriefs are saved on the shared drive after each incident and documented with incident reports.	Regular team meetings to discuss staff wellbeing
2 Regular equality and diversity meetings held with cultural team.	2 Information cascaded to wider team via email and opportunities given to meet with team.	police liaison to visit patients on wards for educational purposes
3 staff who have been subject to racial and/or physical abuse are supported to contact police if felt necessary	3 police reports are added to RiO progress notes.	Training to be provided to all staff 'hate crime training'
4 plan of care for individual patients reviewed to mitigate risks.	4 care plans and section 17 leave prescription updated to reflect changes.	For all staff to complete training in PMVA and refreshers to be offered to build confidence if necessary. On site support from PMVA instructor.
5 unison attend ward on a weekly basis to offer support to wider team.	5 Email correspondence between ward manager and unison	

Ref: 2624 v.3

Risk Owner: Ramona Duguid

Next Review Date: 17/05/2024

Review/Comments:

17/04/2024 - Yvonne Newby - In line with new risk management policy this risk will be escalated to CRR 16+ risk register. Samantha will remain the handler of the risk and carry out day to day management, Ramona will be the new owner of the risk until risk is mitigated and de-escalated.

8. ANY OTHER BUSINESS / ITEMS FOR INFORMATION

Darren Best, Chair

8.1 CHAIRS REPORT

Darren Best, Chair

For Information

REFERENCES

Only PDFs are attached

8.1 Chairs Report June 2024 DRAFT 02.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 5 June 2024**
Title of report	**Chair's Report**
Executive Lead	**Darren Best, Chairman**
Report author	**Kirsty Allan, Corporate Governance Manager / Deputy Trust Secretary**

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

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

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

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

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

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

Meeting of the Board of Directors
Chair's Report
Wednesday 5th June 2024

This is a regular report for information and accountability, summarising my activities as Chair and Non-Executive Directors (NED) activities and key events since the last Board meeting on 6th March 2024.

Wearmouth View – Monkwearmouth Hospital

Work began on the new building back in August 2022, with the demolition of the old building which had become structurally unsound and unfit for purpose. I had the opportunity to visit Wearmouth View as the work was completed in March 2024 and the staff are now using the building. This is a fantastic development which brings much needed investment to the Monkwearmouth Hospital site, and has brought real benefits to service users, staff and visitors. The new building provides modern, efficient, purpose-built working environments, designed in partnership with staff, to promote better teamwork and help staff provide excellent care. It will enable us to continue to provide community mental health support, for all ages, from a safe and accessible site in the heart of the community of Sunderland.

Board of Directors and Council of Governors

As Chair of the Council of Governors and Board of Directors, I participated in the following:

- Quarterly Governor representative discussions
- Council of Governors Business Meeting
- Council of Governors Development Session
- Board of Directors meeting
- Board Development Session

I am grateful to Brendan Hill (Vice Chair) for stepping in and Chairing a Board meeting and a Governors meeting that I was unable to attend during this period.

NTW Solutions Board Development

A workshop took place on 30 April, at which the NTW Board, CEO and senior managers reviewed progress against their objectives and identified priorities for the coming year. I attended primarily to hear and learn about the wide ranging and fantastic work that NTW Solutions does with and on behalf of the Trust. I was made to feel very welcome and was given the opportunity to provide some thoughts around the importance of the voice of the service user and carer and our staff in shaping how we do things. I learned an awful lot about the breadth and quality of the services we get from NTW Solutions.

We are lucky to have a business partner who truly understands the importance of how their work impacts on how CNTW delivers services. It was clear to me that the values that NTW Solutions operates with are seamlessly aligned to those of CNTW. I look forward to receiving the NTW Solutions Annual Report at a future Board meeting.

Appointment of Non-Executive Director (NED)

Following the December 2023 recruitment process we interviewed an excellent candidate, Robin Earl who has a strong business background and his values aligns with the values of CNTW. Robin will be joining the Board of Directors as a Non-Executive Director in July which allows for a period of handover for when David Arthur's term of office comes to an end in January 2025. I will be meeting with Robin in his first week of starting in post to oversee the completion of his induction programme and agree objectives as a supporting personal development plan for the current financial year.

I am also in the process of undertaking all Non-Executive Directors appraisals. The appraisals process is important to ensure that Non-Executive Directors develop their skills, feel motivated, well supported, and confident to deal with many issues and challenges they will face in their role. An effective appraisal will enable Non-Executive Directors to evaluate their performance, receive constructive feedback, build on strengths, and address any areas of improvement.

Arrangements are in place for our Trusts Senior Independent Director, David Arthur to complete my appraisal as Chair, in accordance with guidance and a framework issued by NHS England. The outcome of the appraisal process will be shared with the Council of Governors' Nomination Committee (for Chair and NED appraisals) and the Remuneration Committee (for Chief Executive and Executive appraisals) and will be used to inform the overall Board development needs moving forward.

Evaluating Council of Governors Effectiveness

Evaluating Council of Governors effectiveness on an annual basis is essential to ensure that the group is operating as effectively as well as helping in identifying areas for future development. To evaluate the effectiveness of the Council of Governors is not only good practice but is outlined as a recommendation in NHS England's code of governance.

The Council of Governors will be undertaking a self-effectiveness questionnaire during May/June 2024 and once needs are identified, a tangible action plan will be implemented to ensure that the Council continues to make improvements every year. The results will be provided to a future Council of Governors meeting later in the year.

Quality Priorities 2024/25

As we are gearing towards our annual report, work is ongoing to review work that has been undertaken over the last financial year and I am pleased to note the Trust has delivered much of what we set out to do in the year but absolutely recognising that we need to go further. We have engaged with partners and stakeholders to account for what we have delivered in 2023/24 and to agree what our priorities for quality need to be for 2024/25.

As a Trust we are committed to providing the highest standard of care and to achieve this we listen to the views of our service users and carers, staff, partners and other stakeholders with the our aim to ensure we continue to improve our services to achieve our vision to work together, with compassion and care to keep you well over the whole of your life as in all of this the voice of those who need our support is paramount. To help us deliver our commitments and the care we strive to achieve we have five strategic ambitions set out in our Trust strategy 'With you in mind'. The report which will be published soon outlines those priorities for 2024/25 which will help us continue our journey to achieving our strategic ambitions.

Internal Engagement & Discussion

I have regular planned meetings with our lead Governor Anne Carlile and meet weekly with James Duncan our Chief Executive Officer. I have also met with numerous individuals, including Executive Officers, Senior Managers and members of staff; the primary aim of which is to inform discussions with the Board and help shape our thinking and decision making.

During March - May 2024, I visited and / or met with:

- Cleadon Ward - Monkwearmouth
- Safety, Security and Resilience Team
- Trust Innovations
- Disability Network
- Library Services
- Audit One
- Service User and Carer Reference Group
- Carleton Clinic – Carlisle
- Crisis Team – Portland Square Carlisle
- OpCourage Veterans Mental Health and Wellbeing Service
- Mitford – Northgate
- Inpatient Services – St Georges Park
- Ward Managers Community of Practice event

Non-Executive Director and Governor Service Visits

Non-Executive Directors and Governors have started their monthly service visit programme 2024. These visits are hugely important which offers the opportunity for Non-Executive Directors and Governors to see where the work happens within the Trust and build relationships with staff based on mutual trust. The visits are an opportunity to get an overview of what is going on in the workplace, offering the ability to gain insights into potential improvement opportunities and acknowledge the fantastic work of staff and be confident and determined to deliver what we say we will in our strategy, 'With you in mind'.

Freedom to Speak Up

I would like to raise the importance of our Freedom to Speak Up Guardians and Champions. Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon. When things go wrong, it is vitally important to learn lessons and make improvements and if you think something might go wrong, you must feel able to speak up to prevent potential harm. Even when things are good but could be better, you should feel able to say something. You can speak up about anything that gets in the way of patient care or affects your working life. This could be something that doesn't feel right to you, for example, a way of working or a process that isn't being followed, you feel you are being discriminated against, or you feel the behaviours of others are affecting your wellbeing or that of your colleagues and patients.

I always go by, if in doubt speak up. It doesn't matter if you are mistaken or if there is an innocent explanation for the matters you raise. As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issues you raise.

Local and Regional Network meetings

As part of my role as Chair of CNTW, it is important to continually be connect to the local and national agenda by meeting key individuals for mutual benefit, to sustain strong relationships, and to continue discussions on key issues.

In this period, I have attended:

- ICS FT Chairs Meeting
- ICB Chair and Foundation Trust Chairs Forum
- North East and North Cumbria Foundation Trust Chair / CEO Workshop
- Provider Collaborative CEO / Chairs Meetings
- North Sub ICP Chairs monthly meeting
- Central ICP meeting
- Mental Health Chairs weekly conference calls
- Foundation Trust Chairs Meeting

Myself and James Duncan, Chief Executive recently attended a ICB Chair and Chief Executive workshop / meeting which was attended by all Trusts in the ICB area. The session further highlighted the financial challenges faced by the NHS and the importance of effective and high-quality governance to oversee spending plans and how we need to continually challenge ourselves to ensure resources are used wisely and in the best interest of patients.

By way of some background / explanation, each Integrated Care System (ICS) is overseen by an Integrated Care Board (ICB). The ICS encompasses all the of Trusts that operate within its geographical area, (in our case the North East and North Cumbria) but more widely is a partnership that brings together NHS organisations, local authorities and other organisations to plan services, improve health and reduce inequalities. The ICSs are legally bound to plan and fund most NHS Services in the areas they control including NHS workforce planning. The systems are also required to bring together a broad range of organisations which have an influence on people's health, including councils, voluntary groups, charities and a host of NHS staff – to create a strategy to tackle public health and social care in each area. By bringing all of the resources, planning and delivery under on

system, the ICSs are intended to improve and join up health and social care. They became operational in July 2002 under the Health and Care Act, with a specific aim of 'enhancing productivity and value for money'.

On that basis, it is important that the CNTW Board operates with an understanding that we are part of a wider system, we rely upon the ICB for our funding and therefore should expect to be appropriately accountable to the ICB for our spending plans and service delivery. I fully expect the ICB to introduce further mechanisms to ensure active governance can be demonstrated, I am optimistic that whatever mechanisms are introduced will be proportionate and useful in respect of improving services to patients.

Collaboration & Partnership

Four Northern Hospitals Trusts are looking to work more closely than ever before as part of a new arrangement to be called 'The Great North Health Alliance'. The Newcastle Hospitals, Northumbria Healthcare, Gateshead Health and North Cumbria Integrated Care NHS Trust will work together in hope of improving healthcare pathways for patients. Plans are in the early stages with the idea of building on areas where there is existing collaborative working across hospital teams which will help those Trusts work towards financial and operational sustainability.

For the reasons set out above, i.e. that CNTW operates as part of a wider health care system, and recognising that other organisations such as those involved in the Great North Health Alliance are actively seeking our partnership and collaboration initiatives and activities, it is important that we recognise that we are already a good and successful partnering organisation, but equally recognise that we could do more. On that basis I have asked James, our CEO, to develop a CNTW Collaboration & Partnership Strategy that will help provide clarity, direction and purpose as to what and where we think working with other organisations could be beneficial in terms of service delivery, efficiency and / or financial savings.

Darren Best
Chair of the Council of Governors and Board of Directors
May 2024

8.2 CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

For Information

REFERENCES

Only PDFs are attached

8.2 CEO Report to Board of Directors June 2024 (002).pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 5th June 2024**
Title of report	**Chief Executive's Report**
Executive Lead	**James Duncan, Chief Executive**
Report author	**Jane Welch, Policy Advisor to the Chief Executive**

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

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

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

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

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

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

Meeting of the Board of Directors
Chief Executive's Report
Wednesday 5th June 2024

Trust updates

Deaf Mental Health Conference

The Deaf Mental Health Conference was held on 8th May in Deaf Awareness Week. This was a collaborative event held at St. James's Park and organised by CNTW, Northumbria Healthcare, Newcastle Hospitals and Deaf Link North East. The event attracted around 100 attendees and included a range of speakers including Dr Margaret De Feu, a Consultant Psychiatrist with extensive experience setting up and delivering mental health and deafness services across the UK and Ireland. Our Lead for Equality, Diversity and Inclusion Chris Rowlands presented an overview of the legal aspects and organisational responsibilities in terms of providing accessible services and information for our service users. Two service users who have accessed different parts of the pathway – in primary, secondary and tertiary services, shared their stories. Their experiences highlighted some of the challenges and barriers that people face. Claire Hoggeth, a Healthcare Navigator from Deaf Link North East provided an overview of her role and the importance of being attuned to the needs of the Deaf community and working with them to enable access to care.

In the afternoon session, Christine Davidson and Heather Common provided an overview of the Mental Health and Deafness Service. The presentation of a case study generated an in-depth discussion surrounding Deaf people's access to mental health services, and open and honest debate and challenge regarding the current situation and provision available. This discussion then fed into a larger action planning session aimed at making positive changes across the system. These actions were wide-ranging and encompassed smaller practical team-level changes, through to more organisational and commissioning level recommendations.

The organising group are in the process of arranging an evaluation of the event. This will include attendees' views and feedback as well as the full action plan from the day. Progress on some of the actions has already begun in CNTW, including linking up the Mental Health and Deafness Service with the NHS mental health 111 delivery team to ensure the service is accessible for Deaf service users, and linking in with Trust Innovations to improve accessibility within the West Cumbria transformation offer.

Social Work Conference

This month I also attended CNTW's Social Work Conference. The morning session focused on mental health social work developments within CNTW and across the NHS, highlighting a 20% national growth in mental health social work and an impressive 43% growth at CNTW since 2022. We shared workforce intelligence, evidencing how diverse social work is across the Trust and how we meet the needs of our communities, with 146 social workers employed across the Trust and 123 within our newly formed Community Care Group.

We discussed the focus of the social work leadership team, including the implementation of key frameworks, support networks and strategic partnerships necessary for social work to thrive. Our keynote speaker, Jak Savage, shared her journey through services as a person

with lived experience, emphasising how social work within health services was instrumental to her recovery.

In the afternoon, a facilitated workshop allowed myself and other strategic leaders to listen to the social work workforce through a speed dating style Q&A, gathering valuable thoughts and reflections to inform key changes aligned to our Trusts strategic ambitions. The outputs from these discussions will be documented for endorsement by our executive leaders.

HOPE(S) Conference

On Monday 13th May I attended the 2nd National HOPE(S) NHSE Collaborative Progress and Future Planning Event in Liverpool. It was an amazing event with many emotive and often challenging to hear stories from Service Users and Carers. We heard from keynote speakers such as Sir Norman Lamb and Dame Baroness Hollins on the impact HOPE(S) has had to support service users and carers to live a life that is based on their human rights and least restrictions.

The event was attended at full capacity, with some international colleagues joining online. This included 33 healthcare providers, academic institutions, CQC and other regulators, and NHSE and ICB colleagues. In relation to forward planning, there was significant commitment from people at the conference to support the HOPE(S) programme gaining further funding to extend and increase its reach into the future. A number of suggestions were made relating to how the programme may be embedded in ICBs, Trusts and the Independent Care (Education) and Treatment Reviews (IC(E)TR) process.

It was a powerful day and we were challenged to consider how we ensure the HOPE(S) work continues to be embedded in every day practice across our organisations and communities. We are very lucky to have a small HOPE(S) team within CNTW who have led some amazing work and I have asked Sarah Rushbrooke to lead on a comprehensive review of human rights work across the whole trust.

24/7 Community Pilot Bid – West Cumbria

NHS England (NHSE) have invited Providers to submit bids to be included in NHS England's Quality Transformation Programme's Mental Health 24/7 community pilot programme, with submissions due by the 26 May 2024. CNTW are hopeful of success and have secured system wide support for a bid, in collaboration with third sector colleagues, for a centre in Whitehaven which will be an open access, no referral model incorporating up to four short stay beds alongside combined crisis and CTT teams, with third sector input, wrapping around the individual in need and supporting them whilst in crisis and onwards throughout their recovery.

It is anticipated that funding associated with a successful bid would be used to create new services which would make a lasting change to local services in West Cumbria. NHSE will be working with pilot sites for 2 years and testing the approach to understand whether savings can be realised to maintain the new model through transforming existing services and models. NHSE are not specifying a set amount of funding per pilot site, recognising the different sizes and scope of submitted bids although bids of up to £2.5m per site are

expected with funds available from July 1st 2024. The funding is non-recurrent and will be available for 2 years; a second round of funding will be available in April 2025.

National updates

Culture of care standards for mental health inpatient services

NHS England published 'Culture of care standards for mental health inpatient services', which sets out the culture of care everyone should experience as a mental health inpatient, regardless of age. The standards apply to all NHS-funded mental health inpatient services, including those for people with a learning disability and/or autistic people, specialist, secure and children and young people's services. The standards have been co-produced with people with lived experience of inpatient services and their families; nurses, psychiatrists, psychologists, allied health professionals and other staff who work in inpatient settings; voluntary sector organisations; royal colleges; and academic experts. The standards are ambitious and describe a positive workplace culture which is critical for improving patient outcomes and where every person has the power to make a difference. The guidance sets out 12 overarching commitments:

1. Lived experience: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight.
2. Safety: People on our wards feel safe and cared for.
3. Relationships: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe.
4. Staff support: We support all staff so that they can be present alongside people in their distress.
5. Equality: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes.
6. Avoiding harm: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs.
7. Needs led: We respect people's own understanding of their distress.
8. Choice: Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care.
9. Environment: Our inpatient spaces reflect the value we place on our people.
10. Things to do on the ward: We have a wide range of patient requested activities every day.
11. Therapeutic support: We offer people a range of therapy and support that gives them hope things can get better.
12. Transparency: We have open and honest conversations with patients and each other, and name the difficult things.

For each commitment, the guidance describes a set of standards and what implementing these standards means for providers in practical terms.

Government response to the rapid review into data on mental health inpatient settings

The government responded to the report of the independent rapid review into data in mental health inpatient settings chaired by Dr Geraldine Strathdee, which was published in June 2023. The rapid review was commissioned by ministers to produce recommendations for improving the way data and information is used in relation to patient safety in mental health inpatient care settings and pathways, and followed undercover investigations by BBC Panorama and Channel 4's Dispatches. The rapid review organised its findings into five key themes: 1) Measuring what matters; 2) Patient, carer and staff voice; 3) Freeing up time to care; 4) Getting the most out of what we have; and 5) Data on its own is not enough. The Government's response to the recommendations made by the review under each theme are summarised below:

1. Measuring what matters
    - NHS England will deliver a programme of work to agree with experts by experience, the CQC and system leaders the most impactful metrics for spotting early warning signs of quality and safety by early 2024.
2. Patient, Carer and Staff Voice
    - DHSC and NHS England expect that by Spring 2024, providers will:
        - Review their approach to Board reports to ensure they can identify, prevent and respond to patient safety risks in inpatient mental health settings.
        - Review lived experience representation at Board level and communicate how it will be strengthened if necessary.
        - Review approaches to gathering and acting on patient experience measures in mental health inpatient settings.

Government also highlights the need for trust leaders to prioritise spending time on inpatient wards including unannounced visits. DHSC and NHS England expect providers to implement relevant carer standards, routinely seek carer feedback, develop co-produced quality improvements, and identify ways to incorporate the expertise of carers to, for example, co-deliver staff training programmes. The Government agrees more should be done to strengthen the expectation that all mental health inpatient wards facilitate visitors, and that mechanisms are in place to act on their feedback. It expects all providers to provide information on the ward environment and therapeutic activity to patients in accessible formats.

3. Freeing up time to care

The Government recognises that providers and commissioners should have access to digital platforms containing core patient data, benchmarking data and which avoid duplicating data submissions, but highlights that this would have funding implications. NHS England will scope out options for this in early 2024 to inform the next spending review cycle.

4. Getting the most out of what we have

DHSC and NHS England will work with Integrated Care System Leaders to help them facilitate sharing of best practice across the sector – it is expected that the outcomes of the 'measuring what matters' programme will support this work. ICS leaders are expected to ensure the availability of data.

5. Data on its own is not enough

NHS England and DHSC will work with system leaders to highlight the importance of improving Board members' capacity and capability to identify, prevent and respond to patient safety risks – the National Patient Safety Syllabus module is a key tool in this area. All provider Boards should review their approach to board reports and assessment frameworks.

DHSC has convened a ministerial-led steering group to oversee this work and will provide an update on delivery in July 2024.

Implementation guidance 2024 – psychological therapies for severe mental health problems

NHS England published guidance aimed at supporting the expansion of psychological therapies for people with severe mental health problems (PT-SMHP) by upskilling and expanding the specialist psychological professions workforce. The guidance is focused on community mental health services for adults and older adults, and Early Intervention in Psychosis for people aged 14+. Many other services are out of scope of the guidance. The guidance includes an overview of the vision for community mental health services for adults and older adults, psychological therapies competencies and the national training offer, the role of mental health and wellbeing practitioners, outcomes monitoring and the 4 week waiting time standard, and advancing mental health equalities. It sets out the following actions for mental health providers and systems:

- Mental health providers and integrated care boards (ICBs) should develop a specific local strategy for implementing increased access to NICE-recommended psychological therapies for psychosis, complex emotional needs/ 'personality disorder', eating disorders and bipolar disorder.
- The chief psychological professions officer (CPPO), the most senior psychological professional in provider organisations, should lead on the expansion programme of PT-SMHP and the governance behind expanding the psychological therapy workforce in line with this implementation guidance. The CPPO should report on progress with the expansion directly to the trust or provider organisation's board, where there should be a named board-level sponsor.
- The current national training offer is not intended to lead to local disinvestment from delivery of any other psychological therapies and interventions if they are evidence-based and local priorities.

The guidance also includes advice around capacity modelling for different psychological therapies and implications for workforce growth and training pathways.

Drug and alcohol workforce strategy

NHS England and the Department for Health and Social Care published a '10-year strategic plan for the drug and alcohol treatment and recovery workforce (2024–2034)'. Dame Carol Black's independent review of drugs called for transformation of the drug and alcohol treatment and recovery workforce to deliver better outcomes for the people it serves. This strategic plan for the drug and alcohol treatment and recovery workforce outlines the actions required next year underpinned by a £257m investment, and plan for the next 3 years, 5 years and 10 years to achieve this vision by 2034. It has been developed by OHID and NHS England through extensive engagement with the sector.

The strategy is structured around three interconnected workforce priorities: reform; recruit; train, develop and retain:

1. Reform

Effective clinical supervision supports both professional development and evidence-based treatment and recovery. Regulated professionals have a central role to play in leading clinical governance and supervision structures within organisations. With 800 medical and mental health professionals joining the sector by 2025, this will strengthen and enhance clinical governance structures and promote a culture that prioritises workforce wellbeing and career development. This will lead to improved caseload management and improved practice and establish a firm foundation for future workforce development.

2. Recruit

Local authorities and delivery partners must recruit multidisciplinary teams (MDTs) in line with the drug strategy expansion targets, using the workforce calculator to inform MDT workforce planning and in line with the capability framework. OHID and NHS England are leading national initiatives to support improved recruitment with a focus on attracting regulated professionals into the sector, notably, psychologists and psychiatrists.

3. Train, develop and retain

By formalising the training and skills required of currently unregulated roles such as drug and alcohol workers, peer support workers (PSWs) and commissioning roles, these roles will be better equipped to deliver and commission effective interventions. More training placements and posts for regulated professionals will help attract them into the sector and ensure there is capacity to train the next generation of specialists. Building sustainable pipelines of regulated professionals into the sector is crucial, especially for psychology and psychiatry. OHID supported by NHS England will lead national initiatives to improve these pipelines. By March 2025 NHS England will work to secure additional addiction psychiatry training posts to expand the bank of posts currently available, and OHID will explore with the Royal College of Psychiatrists (RCPsych) development of a pathway for consultants to train and demonstrate equivalence to become addiction specialists (credentialing).

NHS England ADHD Taskforce

NHS England has announced the formation of a new Attention Deficit Hyperactivity Disorder (ADHD) taskforce which will work alongside government to improve care and support.

The taskforce will bring together expertise from a broad range of sectors, including the NHS, education and the criminal justice system, to better understand the challenges affecting those with ADHD and help provide a joined-up approach in response to concerns around rising demand. The taskforce will also engage widely across health and care systems. Taskforce membership and terms of reference will be published in the coming weeks, with findings published later this year.

Alongside the work of the taskforce, NHS England will continue to work with stakeholders to:

- Develop a national ADHD data improvement plan.
- Carry out more detailed work to understand the provider and commissioning landscape.
- Capture examples from local health systems who are trialling innovative ways of delivering ADHD services and to ensure best practice is captured and shared across the system.

Cass Independent Review of Gender Identity Services for Children and Young People

Dr Hilary Cass submitted her final report and recommendations to NHS England in her role as Chair of the Independent Review of gender identity services for children and young people. The Review was commissioned by NHS England to make recommendations on how to improve NHS gender identity services and ensure that children and young people who are questioning their gender identity or experiencing gender dysphoria receive a high standard of care that meets their needs, and is safe, holistic and effective.

Key findings from the review include:

- There are conflicting views about the clinical approach, with expectations of care at times being far from standard clinical practice. This has made some clinicians fearful of working with gender-questioning young people, despite their presentation being similar to many children and young people presenting to other NHS services.
- While a considerable amount of research has been published in this field, systematic evidence reviews demonstrated the poor quality of the published studies, meaning there is not a reliable evidence base upon which to make clinical decisions, or for children and their families to make informed choices.
- The rationale for early puberty suppression remains unclear, with weak evidence regarding the impact on gender dysphoria, mental or psychosocial health. The effect on cognitive and psychosexual development remains unknown.
- The use of masculinising / feminising hormones in those under the age of 18 also presents many unknowns, despite their longstanding use in the adult transgender population. The lack of long-term follow-up data on those commencing treatment at an earlier age means we have inadequate information about the range of outcomes for this group.

The Cass Review makes a series of recommendations which include:

- Expanded capacity through a distributed service model based in paediatric services and with stronger links between secondary and specialist services.

- Children and young people referred to NHS gender services must receive a holistic assessment of their needs to inform an individualised care plan including screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment.
- Standard evidence based psychological and psychopharmacological treatment approaches should be used to support the management of the associated distress from gender incongruence and co-occurring conditions, including support for parents/carers and siblings as appropriate.
- The option to provide masculinising/feminising hormones from age 16 is available, but the Review recommends extreme caution. There should be a clear clinical rationale for providing hormones at this stage rather than waiting until an individual reaches 18. Every case considered for medical treatment should be discussed at a national Multi-Disciplinary Team (MDT).

NHS England has published its response to the Cass Review, and will publish a full implementation plan in due course. The letter sets out NHS England's immediate priorities following the publication of the Cass report, including bringing forward its review of adult gender dysphoria service specifications.

Revised Oversight and Assessment Framework

On 23 May 2024, NHS England issued a revised Oversight and Assessment Framework for a 3-week consultation period. The draft framework follows discussion and engagement with Integrated Care Boards and providers on our oversight and assessment approach.

The draft framework reflects the desire of patients and system partners for greater clarity of roles and responsibilities; use of a broader range of short and medium-term outcome measures, less subjectivity in measurement of success, and adoption of mature relationships in supporting organisations to improve.

You can access the consultation draft online and we would encourage everyone to respond.

8.3 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

8.4 DATE AND TIME OF NEXT MEETING

Wednesday 4th September 2024
St Nicholas Hospital Trust Board Room and via YouTube