Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

4 September 2024

15:00 GMT+1 Europe/London

Trust Board Room and via YouTube

AGENDA

1. STANDING AGENDA ITEMS

Darren Best, Chair

REFERENCES

Only PDFs are attached

Board agenda Public SEPTEMBER 24 FINAL.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 and Via Live Streaming**	**Date: 4 September 2024** **Time: 3:00– 4:45pm**

	Item	Lead	
1.	**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 5 June 2024	Darren Best, Chair	Enc
1.4	Action Log and Matters Arising from previous meeting	Darren Best, Chair	Enc
1.5	Chair's update	Darren Best, Chair	Enc
1.6	Chief Executive report	James Duncan, Chief Executive	Enc
2. Strategic Ambition 1 – Quality care, every day			
2.1	Quality and Performance Committee Report	Louise Nelson, Committee Chair	Enc
2.2	Mental Health Legislation Committee Report	Michael Robinson, Committee Chair	Enc
2.3	Learning from the Shanley Report and CQC review of Mental Health Services at Nottinghamshire Healthcare NHS FT	Rajesh Nadkarni, Deputy Chief Executive / Medical Director	Enc
2.4	Integrated Performance Report – Quality care, every day	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance & Dr Rajesh Nadkarni, Deputy Chief Executive/ Medical Director	Enc
3.1	Community hub – West Cumberland update	Ramona Duguid, Chief Operating Officer	
3.2	Integrated Performance Report – Person led	Ramona Duguid, Chief Operating Officer	Enc

	care, when and where it's needed		
4. Strategic Ambition 3 – a great place to work			
4.1	People Committee Report	Brendan Hill, Committee Chair	Enc
4.2	Integrated Performance Report – A great place to work	Lynne Shaw, Executive Director of Workforce and Organisational Development	Enc
5. Strategic Ambition 4 – sustainable for the long term, innovating every day			
5.1	Resource and Business Assurance Committee Report	Paula Breen, Committee Chair	Enc
5.2	Finance Report	Kevin Scollay, Executive Director of Finance	Enc
5.3	Integrated Performance Report – Sustainable for the long term, innovating every day	Kevin Scollay, Executive Director of Finance	Enc
6. Strategic Ambition 5 – working for, and with our communities			
6.1	Charitable Funds Committee	Vikas Kumar, Committee Chair	Enc
7. Governance and Regulatory			
7.1	Audit Committee Assurance Report	David Arthur, Committee Chair	Enc
7.2	Board Assurance Framework / Corporate Risk Register report	Debbie Henderson, Director of Communications and Corporate Affairs	Enc
8. Any other business / items for information			
8.1	UK Covid Inquiry Module 1 Report	Sarah Rushbrooke, Executive Director of Nursing, Therapies, and Quality Assurance	Enc
8.2	Questions from Governors and the public	Darren Best, Chair	

Date of next meeting
4th December 2024, St Nicholas Hospital Board Room and via MS Teams

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 5TH JUNE 2024

Darren Best, Chair

REFERENCES

Only PDFs are attached

1.3 Public Minutes 5 June 2024 FINAL CHECKED.pdf

Minutes of the Board of Directors meeting held in Public
Wednesday 5 June 2024 1.30pm – 3.30pm
Trust Board Room, St Nicholas Hospital and via MS Teams and YouTube

Present:
Darren Best, Chair
Paula Breen, 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
Kevin Scollay, Executive Director of Finance
Lynne Shaw, Executive Director of Workforce and Organisational Development

In attendance:
Anne Carlile, Lead Governor and Carer Governor, Adult Services
Star Masaka, Northumbria University Governor
Margaret Adams, Service User and Carers Reference Group Chair
Neil Newman, Shadow Governor
Emma Silver-Price, Non-Clinical Staff Governor
Kirsty Allan, Corporate Governance Manager / Deputy Trust Secretary
Kelly Jackman, Web & Digital Communications Officer
Kim Carter, Acting Workforce Developments Manager
Sheila Williamson, Executive Assistant (minutes)
Members of the public were in attendance

STANDING AGENDA ITEMS

1.1 Welcome and apologies for absence

Darren Best welcomed everyone to the public board live which was being streamed on YouTube. Introductions were made from board members and apologies for absence received from:

- Debbie Henderson, Director of Communications and Corporate Affairs
- David Arthur, Senior Independent Director/Non-Executive Director
- Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance
- Brendan Hill, Vice-Chair/Non-Executive Director

1.2 Declarations of interest

Rachel Bourne indicated her brother-in-law is a Psychologist at St Nicholas Hospital. There were no other conflicts of interest declared for the meeting.

1.3 Minutes of the meeting held 6 March 2024

The minutes of the meeting held on 6 March 2024 were considered and agreed.

Approved:
- **The minutes of the meetings held 6 March 2024 were approved.**

1.4 Action log and matters arising not included on the agenda

None to note.

2. STRATEGIC AMBITION 1 – QUALITY CARE, EVERY DAY

2.1 Quality and Performance Committee Report

Louise Nelson provided the report for information and highlighted the development of the new Violence and Aggression Steering Group. Louise highlighted the revised Safer Staffing report, which is aligned to the Integrated Performance Report (IPR).

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 noting the Trust has undertaken a review of detention under the Mental Health Act (MHA) in North Cumbria to compare with national trends and data and are further looking at the use of detention across the region.

Michael discussed the review of panel membership including exploring various ways to increase representation from diverse communities.

Resolved

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

2.3 Integrated Performance Report – Quality care, every day (Month 1)

Darren Best advised the Trust has an overall Performance document divided into the relevant section and this part relates to Quality care, every day.

Rajesh Nadkarni referred to the three metrics in the report including work around restrictive practices, violence towards staff and patients and looking at people's rights. The discussion focussed on reduction in restrictive practices.

Darren commented the desired trajectory is to reduce the number of restrictive practices as quickly and safely as possible and find the appropriate balance between quality care and maintaining patient and staff safety.

Resolved:

- **The Board received and noted the Integrated Performance Report for ambition 1- Quality Care Every Day**

3. STRATEGIC AMBITION 2 – PERSON LED CARE, WHERE AND WHEN IT'S NEEDED

3.1 Integrated Performance Report – Person led care, when and where it's needed

Ramona Duguid commented on key areas of focus from a quality perspective and reported the Trust continue to be in a strong position around out of area placement bed days and have seen improvements in Psychiatric Liaison performance within emergency departments across the patch.

Ramona referred to the national measure over four week waits for access to care and treatment introduced last summer to ensure work around community transformation and model of care reflects trajectories in place between now and the rest of the year.

Resolved

- **The Board received and noted the Integrated Performance Report for ambition 2- Person Led Care, when and where it's needed**

4. STRATEGIC AMBITION 3 – A GREAT PLACE TO WORK

4.1 People Committee Report

Lynne Shaw reported the training review is now complete and will be reflected in the performance report and the staffing review will be included once complete. The Committee have agreed to have two Workshops in June and in November to provide an opportunity to look at areas in more detail noting the June Workshop will be covering retention and employer relations.

Resolved:

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

4.2 Safer Staffing Report

Rajesh Nadkarni referred to the issue across some of the wards looking at the experience of nursing leadership and supporting the high proportion of preceptees and international nurses.

Rajesh referred to the challenges in certain services including a combination of complex physical health issues and how people manage to deal with their condition in an inpatient setting.

Louse Nelson discussed the inexperienced nursing workforce and capacity for supervision and suggested looking at supervision for students. She suggested that this has an impact on how many students can be employed from an area and proposed looking at how the Trust can develop a relationship with higher education institutions.

Rajesh agreed there are challenges in both nursing and medical students joining the Trust, But also commented on the significant support that is in place. Darren Best commented on the extra support the Trust can put in place.

Michael Robinson asked whether the recent restructuring had had an impact on our ability to manage safe staffing in wards and Ramona commented on the improved ability to standardise and employ best practice. Michael also commented on the changes that had been made to preceptorships in terms of increasing flexibility across ward and community teams. James and Ramona commented that this was having a positive effect in terms of staff morale and retention.

James Duncan referred to the short-term challenge of working with higher numbers of inexperienced staff across the organisation but also saw this is an opportunity to develop a more sustainable long term workforce. Significant effort is being put in to manage this period well and offer newly qualified and international staff the support training and knowledge that they need.

Ramona Duguid noted this directly links into the significant work around the Workforce Plan looking at the model of care and how we ensure we have the right competency framework in place.

Rachel Bourne queried the reference to mixed wards creating risks relating to sexual safety and whether these risks are being realised and are reported through the IPR.

Ramona advised the Trust already look at all sexual safety related incidents which are investigated through the Trust wide Safety Group (TSG) and referred to the medium term plan in place to improve sexual safety through the transformation programme.

Resolved:

- **The Board received and noted the Safer Staffing Report.**

4.3 Equality, Diversity and Inclusion Report

Lynne Shaw highlighted the initiatives and events carried out this year and referred to the launch of cultural diversity events, which have been well received well by staff and service users. She also

discussed the cultural lab created by staff and the popular lunch and learn sessions arranged by the disability staff network.

Lynne noted the recently reestablishment of Armed Forces and Veterans Association as a formal staff network. The report also details the latest Workforce Race Equality Standard and Workforce Disability Equality Standard data from March 2023 and highlights Gender Pay Gap report for 2022/23 and the three key Equality, Diversity and Inclusion Objectives approved by the Board in November.

James Duncan commented the Armed Forces and Veterans network does have a different standing and is part of a nationally established and recognised network, and therefore deserved the same status as those networks already established for protected characteristics. Daren Best welcome this approach. James also commented on the cultural celebration events which have been fantastic. He also mentioned the lunch and learn sessions provided by the Disability network that have been excellent with some inspirational speakers and recommended Board members join any of these events.

Darren Best gave thanks and appreciation of all the staff networks and their commitment.

Resolved:

- **The Board received and noted the Equality, Diversity and Inclusion Report.**

4.4 Raising Concerns Report

Lynne Shaw presented the report and advised there have been sixty concerns raised internally and two whistleblowing cases received via the CQC. 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. The other key theme is policies and procedures linked to employee relations processes. For example, where a staff member has had a restriction placed on them whilst undergoing a disciplinary process and training has been rolled out currently for fact finds and there is a programme of work to look at to address themes from this report.

In terms of cases a large proportion originate from community services and the Freedom to Speak Up Guardian (FTSUG) have noted an increasing trend in North Cumbria. The team are looking at details further and the Guardians have indicated a greater number of concerns raised confidentially and the Trust are looking to explore further with the Trust Leadership Forum and the Guardians.

Michael Robinson queried if there are any whistleblowing hotlines entirely independent of the organisation and Lynne advised some Trusts including one of the local Trusts are going down that route, but our Trust has not explored that as yet. Michael noted that he did not think this was a good idea as he felt knowledge of the organisation is important to deal with issues effectively and to gain Trust.

Lynne commented that the Trust have around 120 FTSU Champions and they are great advocates across the whole organisation in all professions and are helping with this work moving forward.

Rachel Bourne commented on the significant increase of FTSU cases and whether it changes each year and Lynne advised there is usually some fluctuation, however the Trust has seen specific wards and areas in which multiple people have raised concerns linked to the same issue and will be observing the increase.

Darren Best noted the Trust do encourage people to raise concerns and to have the confidence in terms of them being supported when speaking up.

Resolved:

- **The Board received and noted the Raising Concerns Report.**

4.5 Staff Survey 2023 Report

Kim Carter, Acting Head of Workforce Developments presented the Staff Survey and discussed the summary of results from the 2023 survey. National headlines response rate was 48% with an increase of people saying they would recommend their organisation as a place to work but it does remain below the levels reported in 2019/2020.

CNTW headlines response rate was 41% and this was the first fully online survey. Kim provided an overview of themes and advised the Trust has performed above benchmark average in five of the seven areas and the two areas where the Trust has not performed above average is 'Staff Engagement and We are a team'.

The Trust's highest score is 'We are compassionate and inclusive'. In terms of the areas of concern for CNTW there was a decrease in 5 areas including staff being able to speak up and staff being treated fairly involved in error, opportunities for career development, teams having enough freedom to do their work and the organisation taking positive action on health and wellbeing.

Kim highlighted the continued communication to staff from previous staff surveys and quarterly staff survey results around themes of the People Promise and the review of the appraisal policy to support embedding of 'With You in Mind' values.

Lynne Shaw outlined the key aims for the year ahead including key areas of engagement in line with the staff survey including the following:

- Freedom to make decisions
- Staff treated fairly
- Experience of physical violence
- Feeling valued by the organisation
- Support from Line Managers

A discussion ensued around leadership performance and the level of delivery of completing the survey including looking at areas that require improvement and ensure technical issues are resolved.

Resolved:

- **The Board received and noted the Staff Survey Report.**

4.6 Integrated Performance Report-Ambition 3-Great Place to Work

Lynne Shaw highlighted improvement in the measured metrics and referred to new priorities for training established and reported working closely to the trajectories set.

Resolved:

- **The Board received and noted the Integrated Performance Report for Ambition 3**

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

5.1 Finance Report

Kevin Scollay presented the finance report and advised at the end of Month 1 the Trust has reported a £2.5m deficit on Income and Expenditure in line with the plan submitted to NHSE. Kevin referred to the expectation of significant improvement in the latter part of the year non-recurring items such as asset sales materialised, as this is how the Trust are expected to deliver the plan for this year.

Kevin highlighted positive news in Month 1 as agency costs have reduced to less than £1m, which is under the agency limit and good news from a financial and quality perspective.

The Capital programme is expected to have some pressure this year although is £0.3m behind plan in the first month and the Trust continues to forecast slippage against the overall capital programme moving through the year.

In terms of the cash position this is slightly below plan and broadly not too far away although the Trust are expecting to see cash balances reduce throughout the year predominately due to the way the Trust are delivering the plan, relying on a number of non cash items. The deficit is referred to in more detail in the annual plan.

Resolved:

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

5.2 Annual Plan and Priorities

Kevin Scollay presented the annual plan including the workforce trajectory and the annual plan priorities. Kevin advised the Trust has submitted a final plan showing a £3.9m deficit having agreed to deliver quite a challenging efficiency target which will be a theme of reporting this year.

The capital has been submitted as a compliant plan. Workforce activity trajectories are outlined and will be subject to ongoing review. Annual plan priorities have been agreed after comprehensive engagement with the Trust Leadership Forum.

Rachael Bourne queried the break-even position as a trust wide priority as it looks likely this is not going to be possible. Kevin Scollay stated the Trust's priority is to be sustainable in the long term and the nationally required target is to deliver break even. Given the planning discussion that have taken place over the previous months nationally and across the Integrated Care System the Trust has proposed and agreed to deliver a £3.9m deficit.

Darren Best indicated the Trust have presented an honest professional assessment of the current position including the deficit although that does not lessen the Trust's ambition to close the gap.

The Committee discussed the clear aims and ambitions and the financial constraint including how to deliver safe services and the necessity to set a plan the Trust can deliver coherent in which quality and workforce are essential.

Resolved:

- **The Board received and noted the Annual Plan and Priorities.**

5.3 Integrated Performance Report -Sustainable for the Long Term

Kevin Scollay provided the report for information.

- **The Board received and noted the Integrated Performance Report-Ambition 4.**

5.4 Resource and Business Assurance Committee report

Paula Breen highlighted the great work the Digital Team have carried out including the implementation of the enhanced 111 service and the formation of a digital partnership with the ICB. Electronic prescribing currently in the Trust's Inpatient Services is to be rolled out to Community and Addiction Services and digital compliance with the Data Security and Protection Toolkit (DSPT) is on track and cyber security layers in place to strengthen backup systems approved at a recent audit.

Resolved:

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

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

6.1 System working report / policy updates

James Duncan advised due to the Election being called the report has not yet been shared with the Integrated Care Board (ICB).

Action:

- **James Duncan to provide a system working report / policy update to a future Board.**

6.2 Charitable Funds Committee

Vikas Kumar advised the team has been working strategically across the Charity Chairs Network to identify joint working and referred to the great work carried out by staff and noted the Marketing Officer and Apprenticeship Post have been really impactful as part of the Charity's Committee and are looking at how to sustain the role.

Vikas referred to the improved communications and engagement to support the charity outlines the positive impact initiatives can have on the wellbeing of carers and patients and discussed the ongoing work promoting the charity including posters on buses and several Great North Run fundraisers.

Resolved:

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

7.1 Audit Committee Assurance Report

Kevin Scollay presented the report and highlighted the core assurance audits remain on schedule to be completed in time for the Head of Internal Audit Opinion and the Internal Audit programme continues to be aligned to the Trust's Board Assurance Framework.

Resolved:

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

7.2 Fit and Proper Person Requirements (FPPT) Report

Lynne Shaw advised 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.

Additionally, DBS checks are now required to be conducted at least every three years. All relevant checks have been undertaken and there are no issues to note.

Lynne gave thanks to Kirsty Allan for the huge piece of work in collating the information.

Approved:

- **The Board approved the new Fit and Proper Persons / declaration of interest annual review.**

7.3 Modern Slavery Statement

James Duncan referred to the report and confirmed the Trusts commitment to the statement which is a legal requirement.

Approved:

- **The Board approved the Modern Slavery Statement.**

7.4 Board Committee Terms of Reference

- **Quality and Performance Committee**
- **People Committee**
- **Audit Committee**

For information.

Resolved:
- **The Board received and noted Committees Terms of Reference**

7.5 Board Assurance Framework/Corporate Risk Register report
Ramona Duguid referred to the thorough review of the Board Assurance Framework (BAF) strategic risks to ensure they reflect the areas at more significant risk.

The Trust has completed internal audit around assurance mechanisms and have received substantial assurance from internal auditors.

James referred to risk 2624 risk of violence and aggression towards staff and to ensure the Trust achieve the right balance between maintaining staff safety and ensuring a human rights approach for service users in light of the ongoing debate. He asked that this be considered by Q and P as a strategic risk to be included in the Board Assurance Framework.

Darren Best suggested looking at the Trust's approach to risk management including Board Assurance Framework in the next Closed Board session.

Action:
- **Discuss Board Assurance Framework / Corporate Risk Register report at next Closed Board**

8. Any Other Business, Items for Information

8.1 Chair's Report
Darren Best presented the report for information and gave thanks to Kirsty Allan for summarising details of activities since the last Board and referred to evaluating the Council of Governors effectiveness and the work ongoing around developing that skill set.

Darren referred to the Collaboration and Partnership and the veterans work CNTW is leading on and suggested looking at a strategy of who the Trust could partner or collaborate with.

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

8.2 Chief Executive report
James Duncan referred to the recent Deaf Mental Health conference and the need to recognise the deaf community is one of the most disadvantages when it comes to health and equality and stressed the importance of developing accessible services around community transformation.

James attended the Social Work Conference and highlighted the opportunity to develop social work in the organisation to support the Trust Transformation programme and model of care and support.

24/7 Community Pilot Bid in West Cumbria. James referred to a visit from the national team and the real opportunity to create services which would make a lasting change to care and support in one of the most disadvantaged communities.

James noted there has been 1,500 nominations for this year's Staff Awards.

Resolved:

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

8.3 Questions from the public

There were no questions from the public.

Date and time of next meeting

Wednesday 4 September 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 September 2024.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting held in public

Action Log as at 4 September 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

1.5 CHAIRS UPDATE

Darren Best

REFERENCES

Only PDFs are attached

1.5 Chairs Report.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 4 September 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 4th September 2024

It is fair to say that a lot has happened both locally and nationally since my last report in June 2024. Events, including a change of Government, local elections, and more recently the disgraceful racist rioting and disorder that we have seen in some of our towns and cities has understandably caused fear and unrest.

At the beginning of August, I was away on holiday with my family, however I was regularly reading and watching the BBC news; I found myself saddened, disgusted and at times angered by what I was seeing and reading. I was particularly appalled to hear of our healthcare workers being targeted with abuse and violence. There is no excuse or justification for what has been happening, it has been pleasing to see a robust response from the authorities and the courts, combined with strong evidence of communities rejecting the violence and pulling together to repair damage and show support to each other.

Amongst the news reports, I was also receiving the messages that CNTW was sharing with our staff, it was very clear that the organisation had rightly adopted a supportive, caring approach, particularly towards those people who were feeling vulnerable and worried. It was also clear that CNTW sought to show strong moral leadership and absolute support for decency, fairness and humanity in communications and activities that utterly rejected all forms of racism and / or bigotry. Through the Executive Team I have thanked and praised everyone involved for their collective efforts, amongst the lows of that week. I personally took some comfort from the efforts and care that CNTW was taking.

The day after I returned from leave, I attended a meeting that had been organised by our Cultural Diversity Network, the aim of which was to allow people to share their thoughts, experiences and concerns following the rioting. I am hugely grateful to the network for organising the event and to those that shared their experiences. It became even more clear to me that the behaviour and attitudes of the racist bullies and thugs had been profoundly disturbing, and caused real fear, trauma and anxiety to a number of people working for CNTW. I am sure those same feelings will have been, (and likely still are) prevalent in our communities. I learned a lot from the session, a particular example that struck me came from one of the networks who said how in recent days they had felt reassured when people from white backgrounds smiled at them in the supermarket; presumably to show their support and that they did not belong to the groups who had been seeking to frighten and intimidate. I share that here because whilst the example made me sad that it was needed, it also told me that we are a strong society, in which the majority of people are decent, and sometimes even when faced with extreme situations, it can often be relatively small acts of kindness and support that are most vividly remembered.

Anyone who knows anything about CNTW and / or the NHS as a whole, recognises that we would not be able to function properly without the talented people from across the globe that make up our organisation and the wider healthcare system. I am proud to be part of an organisation that readily and regularly celebrates and values diversity.

In this update I want to add further emphasis to the messages that I mention above. CNTW has and will always utterly condemn the violence and the fear that we saw unfold. We should always stand proudly together to say that we all belong, and we are there for each other. I am incredibly proud of our diverse workforce and the communities we serve and live in. CNTW will never tolerate any form of racism, bigotry and / or abuse. We must continue to support people to discuss their fears and / or concerns in a safe way, we should not

forget what happened, but we must learn from it and be open to respectful and compassionate dialogue.

CNTW Culture

During this last period, I have been pleased to see CNTW discussing and working on its organisational culture and what impact culture has on how we do things. I suspect at times the word itself can cause some head scratching in terms of what exactly do we mean by culture, how do we define it and how do we know if we have affected it and / or got it right. I think if people are regularly asking themselves those questions, then in itself that should tell us that we are heading in the right direction.

Since taking up the role of Chair almost a year ago, I have visited numerous wards and services and spoken to lots of our people. Unsurprisingly, with such a large and diverse organisation, I have observed that there doesn't appear to be a single describable culture that is operating across all teams. The nature and history of our services, differing needs of patients and the diversity of our staff means that there are differences in things like daily routines, management styles and how staff work together. That said, what is the same, and should be the basis on which we test and discuss our culture are our Values.

Our strategy, 'With You in Mind', describes what we are collectively seeking to achieve and within that we are very clear about our values. In my view it is those values that form the basis of our CNTW culture; they should be overt and discussed regularly to ensure we are living them. Our values statements should not be seen as passive, from which success will happen without thought or effort, they are active, and we should be determined to see them present every day in all we do. When we are considering doing something, whether it be clinical, or non-clinical, in my view our values should always form the basis for, 'how we do it'. They are statements about how we behave, how we treat others and how everyone should expect to be treated.

- We are Caring and Compassionate – because that is how we'd want others to treat those we love.
- We are Respectful – because everyone is of equal value, is born with equal rights and is entitled to be treated with dignity.
- We are Honest and Transparent – because we want to be fair and open, and to help people make informed decisions.

The Board of Directors has a significant role to play in developing our culture, we must seek assurance and check that we have openness and accountability at every level and that our values are being lived across the organisation.

The culture of the organisation shapes the behaviour of everyone in it, the quality of care it provides and its overall performance, all of which are challenges for CNTW. I recently attended a Trust Leadership Forum where the focus was on culture, it was good to see and hear some very rich discussions and ongoing conversations taking place, with further work being planned. Compassionate and inclusive leadership skills and behaviours are key to enabling cultural changes that will allow us to deliver high quality care, value for money, compassion, freedom to speak up and continuously improve. Signs of high-quality leadership can be found in environments that support learning, that are free from bullying, where there is no complacency and where there is clarity and alignment with a common set of values.

When developing ‘With you in mind’ we asked service users, carers, their families our staff and partners to describe what matters to them. They asked us to work together, with them in mind, with compassion, humanity and care. This is at the heart of the strategy and adds further emphasis to the importance of, ‘how’ we do things, the people we serve have been clear about what they would like our culture to be; we must listen to them.

I also ask people to also pay particular attention to our commitments. Following on from my June report where I highlighted the importance of Freedom to Speak Up, I continue to encourage anyone to speak up if something that doesn’t feel right to you. Examples might be, 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.

Celebrating Staff Excellence Awards

Our Staff Excellence Awards recognise and celebrate the achievements of our staff, volunteers who despite our challenges have gone over and above to support the Trust. This year, more than ever, it’s important we capture that to give people the opportunity to reflect and remember some of the things we are doing well by highlighting some of the great work which takes place across our organisation. The awards which will be taking place on 27th September is a key annual event celebrating many achievements and recognising how far we have come in 2023/24.

I am really looking forward to the year ahead and seeing us progress again, so that we further improve safety, care and services for our service users, carers and community and your experience of working here. I would like to thank everyone who took the time to nominate.

Annual Members Meeting / Annual General Meeting (AGM)

Every year, we hold an Annual Members / Annual General Meeting and celebration event where we bring together the Trust Members, our staff, our Governors, members of the public and our Board of Directors. It is a fantastic day where Members can find out about some of our great work we have been doing over the last 12 months.

This year we will be holding our meeting on Thursday 26th September and as usual there will be a marketplace stalls available with representatives talking about the work taking place throughout the Trust and within our partner organisations and local communities. From 1pm we will be hosting our Annual Celebration Event, which this year is titled 'Voyage to Recovery'.

Our AGM is a great opportunity to reflect on the year passed, acknowledge the challenges that we have faced and celebrate the achievements and improvements which we often don't get the chance to do working day to day. It is easy to focus on "what we are not doing right" but it is extraordinary what colleagues and services have done to improve the care they are able to provide to service users and carers. Incredible improvements have been made in the last 12 months and we are focussed on the further areas we know we need to improve.

I hope you will be able to join us at our AGM and if you would like to book a place for either a stall or come and hear about our celebration event at 1pm, please email members@cntw.nhs.uk

Outcome of Fit and Proper Persons reviews

In August 2023, NHS England published a revised Fit and Proper Persons Test (FPPT) Framework in response to the recommendations made by Tom Kark KC in his 2029 review of the FPPT. The review highlighted areas that needed improvement to strengthen the existing regime. The Framework introduces a requirement for the Trust Chair to submit an annual return to the NHS England Regional Director. The Framework applies to Executive and Non-Executive Directors and as Chair, I applied FFPT to all members of Board members and participants. The Director of Communications and Corporate Affairs received the individual self-attestation forms, completed all the required checks and provided reports for review.

An NHS Leadership Competency Framework was also published which provides guidance for the competence categories against which a board member should be appointed, developed, and appraised. This Framework was effective in this round of appraisals which was used for all new board level appointments and for annual assessments for all board members.

The appraisal for all board members undertaken by me, and the CEO completed the process. David Arthur, Senior Independent Director completed the review of my reports. From this, I can determine that all board members and participants comply with the FPPT, and I have submitted the annual summary to the Regional NHS England Director. This year the completed date was 30 June, but this will come forward to 31 March next year.

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.

Following the results of the Council of Governors self-assessment questionnaire where a few suggestions were identified a Governors focus session has been arranged to devise a tangible action plan to ensure the Council continues to make improvements every year.

Internal and External engagement and activity

In addition to our schedule of planned Board and Governor meetings, I continue to 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. I am aware that our Non-Executive Directors have also involved themselves in a range of visits and meetings to help shape their thinking and discussions with the Governors and the Board.

During June - September 2024, I visited and / or met with:

- Crisis Teams at St Nicholas Hospital and Hopewood Park
- Service User Carer Reference Groups (June / August)
- Castleside and Akenside wards
- Roselodge
- Trust Leadership Forum

Local and Regional Network meetings

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 / met with:

- Integrated Care System, (ICS) Foundation Trust (FT) Chairs Meeting – this is a meeting of all of the Chairs operating in the North East and North Cumbria area. The meeting provides a good opportunity to discuss individual Trust and system wide pressures, concerns and learning.
- Integrated Care Board (ICB) Chair and Foundation Trust Chairs Forum – this meeting is attended by all of the FT Trust Chairs and is Chaired by Professor Sir Liam Donaldson (the Chair of the ICB) with the ICB CEO, Sam Allen and other senior ICB personnel. The meeting provides a forum to discuss system and wider NHS related issues, assess how we in the North East and North Cumbria are performing as a system and understand the strategic / wider issues that impact on the individual Trusts and the system collectively.
- North Integrated Care Partnership (ICP) – our ICS currently has three ICPs' (North, Central and South), albeit the North and Central ICPs' are intending to join together in recognition of the combined authority that operates across the North East. The partnership receives updates on various health related matters and initiatives affecting people in the North East and North Cumbria. CNTW have been asked to provide an update on issues affecting children and young people's mental health services at a future meeting.

- Chair of Tees Esk and Wear Valley (TEWV) NHS Foundation Trust – I met with David Jennings to discuss potential opportunities for CNTW and TEWV to work more closely together with a view to improving services for patients and identifying potential efficiencies. There is much to discuss and further meetings that will include Executive officers will happen in the coming months.

Darren Best
Chair of the Council of Governors and Board of Directors
September 2024

1.6 CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

1.6a CEO Report to Board September 2024.pdf

1.6b. CEO Report - Appendix 1 - NENC ICB Quality Strategy.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**4 September 2024**
Title of report	**Chief Executive's Report**
Executive Lead	**James Duncan, Chief Executive**
Report author	**Debbie Henderson, Director of Communications and Corporate Affairs**

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 4 September 2024

1. Trust updates

1.1 Response to public disorder in our communities

At the beginning of August riots took place across the country and sadly, in some of our local communities and we saw violence and threatening behaviour in events of public disorder. As a Trust we condemn these attacks – there is no place for racism or discrimination of any kind in our organisation or in our communities.

While many of us have found it difficult to process these events, the attacks have created a climate of fear and uncertainty for many of our patients, carers, and staff from culturally minoritised backgrounds. As a Trust, we took action to keep our patients, carers, and staff safe across community teams. This included offering video or telephone appointments, deferral of face-to-face appointments, in agreement with patients, changing appointment venues, supporting staff to work from alternative locations including from home, and putting additional security in place in high-risk areas. Although this response was positively received, I am sad that we had to do it in the first place.

In response to the attacks, we worked closely with the Police and other partners to support the implementation of local plans based on reliable local intelligence about further disorder.

More recently, our Cultural Diversity Staff Network extended an open invitation to all staff to join a listening session with our Executive Team to share their own personal experiences and concerns following the events of the last few weeks, and at that session, our workforce demonstrated their support and allyship to colleagues from culturally diverse backgrounds and each other. I am proud to be part of organisation which embraces diversity and sees diversity of all kinds as a strength.

As a Trust we are absolutely committed to tackling all forms of discrimination in our services, our workforce and in our communities and this will continue to be a priority for the organisation as we move forward. I would like to thank all our patients, carers, staff, communities, and partners who have worked together to keep each other safe during this extremely distressing period.

1.2 New 24/7 Community Hub - Whitehaven

A new community hub will offer round-the-clock mental health support in the heart of Whitehaven. The hub is part of a pilot to provide more mental health support in local communities. It will be delivered by a group of local organisations, led by CNTW, working in partnership, this includes Cumbria Health, Everyturn Mental Health, Home Group, iCan Wellbeing Group CIO, and The Well Communities CIC.

The hub will be life-changing for people in Whitehaven and the surrounding area and will allow us to transform the way mental health care is provided locally. It will bring together specialist health, social care and community services, so people can get the right help, at the right time. We have worked with local people and organisations to get the right people around the table to develop this new service including service users and carers, and we are excited to begin the work to make it a reality, together. The hub will also offer advice on

issues which often affect people's mental health, like housing, money and employment. And there will be support for the families and carers of people who are unwell.

Most radically, the hub will offer an alternative to people needing to be admitted to hospital, by providing four short-stay beds for people who need to be supported at the hub for that little bit longer. The is a significant example of the power of collaboration and what can be achieved working across systems together, for the greater good.

1.3 Northgate Park – The Craft Shack!

On Saturday 31 August families, carers and local residents are welcomed to the hospital for an open day, with the chance to meet the teams who work there and see some of the facilities. Northgate provides a range of mental health and learning disabilities services, including wards for autism, rehabilitation and forensic services. Northgate also houses Sycamore, a state-of-the-art secure facility which opened last year and looks after men with a mental illness or learning disability, who have come into contact with the criminal justice system.

The day will also see the opening of a new shop on site – the Craft Shack. The shop will be run by patients who will be selling things they have made as part of their recovery programme. Items on sale will range from artwork and woodwork to plants.

The Craft Shack will showcase the craftsmanship, talent and skill of the patients that we work with on the Northgate site. They are some of the most vulnerable and let down members of society and we want to celebrate their talents and creativity as they rebuild their lives. We also hope that by raising awareness of our services, we can reduce the stigma around secure services and mental health and learning disabilities in general.

To add to this, all income made from the shop will be reinvested back into patients, with 50% going directly back into services and 50% going to the Trust's charity, SHINE.

The site will be open 12.30pm – 2pm on Saturday 31 August and The Craft Shack will open its doors at 12.30pm.

2. North East and North Cumbria Integrated Care System (NENC ICS) updates

2.1 NENC Integrated Care Board (ICB) Mental Health, Learning Disability and Autism Sub-Committee

At the August meeting of the Committee, we agreed the NENC Clinical Conditions Strategic Plan for Anxiety and Depression. The Committee received the proposed strategy and action plan for anxiety and depression across system. The aim was to seek support for initiating the socialisation and finalisation of system-wide plans for implementation across the ICS.

It was recognised that we will need to engage on the plan with all partners across the system and there was a sense that more specific detailed actions of what and how this would be achieved needs to be further developed.

We also discussed the direction of travel for the NENC ICB Suicide Prevention Strategy and Plan. The Committee discussed the priorities to deliver suicide prevention activity in NHS settings and supporting local activity where economies of scale are appropriate and available. The discussion also focused on the importance of understanding the variance in

suicide rates across NENC footprint which are not always explained by deprivation levels of patients and further analysis of this is needed.

A paper was received on the Housing, Health, and Care Programme Board. The paper outlined the background and scope of the programme and the complex care priority and described the action plan and intended outcomes for 2024/25. The Programme is the region's sector-led housing improvement activity. It is jointly led by the NENC ICB, Directors of Adult Social Services, the Northern Housing Consortium, and the TEC Services Association. It describes a vision that aligns with policy and strategy drivers for the region, focused on three priorities: supporting older people to remain independent, tackling cold and damp homes in the rented sectors, and identifying integrated models of housing and support for people who need complex care and support.

A discussion on the wider determinants of health affect mental health including housing, physical health, wealth and the link to anxiety and depression was also discussed.

2.2. North East and North Cumbria Integrated Care Board – Quality Strategy

In their strategy, Better health and wellbeing for all, NENC ICB share their vision for North East and North Cumbria capturing the need to improve health and broader wellbeing for everyone across the North East and North Cumbria. This includes taking the Learning and Improvement Collaborative comprised of people from across the region to build the learning system as a culture, a community and a collection of assets that support learning at every opportunity. The objectives are to achieve longer, healthier lives for everyone, fairer health outcomes for all, achieve the best start in life for our children and young people and improving health and care services.

The Quality Strategy is being developed to support delivery of the overarching strategy and vision for the system and is underpinned by five strategic themes: culture, patient safety, clinical effectiveness, multi-professional leadership, and positive experiences.

We, along with other Providers across the system, are working with the NENC ICB to ensure that our ambitions and priorities are aligned to those of the wider system so that we can all help bridge the gap between health inequalities, and avoidable harm and provide services which are joined up and meet the needs of those we need us.

The final Quality Strategy will be launched by the NENC ICB on 1 October, the draft is included as Appendix 1 and is available at the NENC ICB website.

3. National updates

3.1 Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust

Following the conviction of Valdo Calocane (VC) in January for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social Care commissioned the Care Quality Commission (CQC) to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT). The first part of the review focused on assessments of patient safety, the quality of care provided by NHFT and the Trust's Rampton high security hospital and was published in March of this year. The second part of the review focuses on evidence related to the care of Valdo Calocane and whether this indicates wider patient safety concerns or systemic issues linked to mental health

services in Nottinghamshire. This second part of the review has now been published which include the key findings of the review.

The review makes a series of recommendations for NHFT linked to review of care and treatment plans, clinical supervision of decisions to detain under Sections 2 and 3, medicines monitoring, family and carer engagement, engaging patients who disengage from Early Intervention in Psychosis, and approach to discharge. The review also makes a series of recommendations for NHS England as regulator.

The Trust's response to the review will be discussed at the September Board meeting.

3.2 NHS England guidance on intensive and assertive community mental health treatment

NHS England published guidance to support integrated care boards (ICBs) to undertake reviews of community mental health services to ensure that they have clear policies and practice in place for patients with serious mental illness who require intensive community treatment and follow-up but where engagement is a challenge. The guidance highlights five key messages:

- Services have a duty to engage with people with SMI and their families and carers – taking into account patients' different backgrounds, experiences, and needs.
- Intensive and assertive community care requires dedicated staff.
- No wrong door approach – which is joined up with other statutory and VCSE services.
- Continuity of care is vital – delivered via a competent and experienced key worker.
- Holistic and engaging care – which is trauma informed and uses biopsychosocial formulation-based approaches to meet the holistic needs of the person (including housing, finance, substance use etc).

The guidance also outlines key themes and lessons from serious untoward incidents, features of intensive and assertive community care services, and defines the scope of the reviews and how they should be undertaken.

The reviews will consider all relevant policies and practices for the delivery of care to people presenting with psychosis (including undiagnosed); who may not be able to or want to respond to routine monitoring; who are vulnerable to relapse and deterioration of their condition and this could lead to serious harm; who have multiple social needs including housing, financial issues etc; who are likely to have co-occurring problems including substance use; who may have had negative experiences of mental health services and other public functions including criminal justice; and where concerns may have been raised by families and carers.

ICBs will also review governance, partnership and monitoring arrangements that support the identification of people who might need intensive and assertive community care, as well as the capacity of local services to provide appropriate levels of care. It is also recommended that local reports on serious incidents, patient experience, and complaints should be reviewed. The reviews are a requirement of the 2024/25 NHS Priorities and Operational Planning Guidance and should be completed by the end of September.

3.3 Review into the operational effectiveness of the Care Quality Commission

The Department of Health and Social Care published the interim report of Dr Penny Dash's review into the operational effectiveness of the Care Quality Commission (CQC). The interim report, which will be followed by a final report in the autumn, provides a summary of the emerging findings and outlines a series of recommendations. The interim report's five recommendations for CQC are:

1. Rapidly improve operational performance.
2. Fix the provider portal and regulatory platform.
3. Rebuild expertise within the organisation and relationships with providers to restore credibility.
4. Review the Single Assessment Framework to make it fit for purpose.
5. Clarify how ratings are calculated and make the results more transparent particularly where multi-year inspections and ratings have been used.

These recommendations reflect the review's interim findings which are:

1. Poor operational performance
    - In 2023-24, fewer than half the number of inspections were completed compared to 2019-20.
    - The average length of time since provider ratings were issued is 3.7 years, with the oldest rating completed in 2014.
    - One in five locations the CQC has the power to inspect have never been inspected.

2. Significant challenges with the provider portal and regulatory platform
    - The deployment of new systems designed to improve operations and communication with providers had resulted in significant issues for users.

3. Considerable loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring.

    - When the CQC was restructured, sectoral knowledge was removed from assessment and inspection teams, placing far more reliance on generalists. Lack of sector expertise means providers do not trust the outcomes of inspections nor have the chance to learn from experts in their fields.
    - Regular interaction between chief inspectors and senior leaders in health and care and with regular inspection teams at a local level was not taking place, even though this had built confidence and enabled early awareness of emerging problems and the wider sharing of good practice.

4. The review highlights concerns around the Single Assessment Framework (SAF), including:

    - There is no description of what 'good' or 'outstanding' care looks like, resulting in a lack of consistency in how care is assessed.
    - There is a lack of focus on outcomes (including inequalities in outcomes).
    - The SAF is poorly communicated internally and externally.
    - The data used to understand the user voice and experience, how representative the data is, and how it is analysed for the purpose of informing inspection, is not sufficiently transparent.

- There is no reference to use of resources or efficient delivery of care in the assessment framework which is a significant gap despite this being stated in section 3 of the Health and Social Care Act 2008.
- The review had found limited reference to innovation in care models or ways of encouraging the adoption of these.

5. Lack of clarity about how ratings are calculated and the use of previous inspection outcomes
    - The review raises serious concerns over the calculation of overall ratings for a provider by aggregating inspection outcomes over several years. Because the CQC is not doing enough inspections to update ratings, the intention of the CQC to phase this practice out over time has not been achieved.

3.4 Labour Government health policy updates

Following the General Election in early July, we now have a new Labour Government and a new Secretary of State for Health and Social Care, Wes Streeting. Since the election, the Government have:

- Announced an independent investigation of NHS performance, which will be led by Lord Darzi and will report in September 2024. The review findings will provide the starting point for developing a ten-year plan for health. The development of the plan will be led by Sally Warren, Director of Policy at the King's Fund, with support from teams at the Department for Health and Social Care (DHSC) and NHS England. Plans for how NHS staff and leaders will be able to contribute to both phases of this work are being developed.
- Agreed a pay deal with the British Medical Association (BMA) Junior Doctors Committee, which if accepted by BMA members, will see junior doctors' salaries rise by 22.3% over two years. The Junior Doctors' Committee has agreed to ballot eligible members on the pay deal. If accepted, the deal will bring an end to industrial action by junior doctors which has been ongoing since March 2023.

The King's Speech was held on 17th July, marking the beginning of the first session of the new parliament since the general election. The King's Speech included several priorities linked to mental health, learning disabilities and autistic people:

- The Mental Health Bill was included in the 2024 King's Speech, demonstrating commitment from the Labour Government to modernise and reform current mental health legislation (the Mental Health Act 1983).
- The speech included a commitment that the government will 'ensure mental health is given the same attention and focus as physical health'.
- There was significant focus in the speech on children and young people's health and wellbeing including a commitment to improving mental health provision for young people, and the introduction of a Children's Wellbeing Bill which will be introduced to raise standards in education and promote children's wellbeing.

3.5 Nursing and Midwifery Council culture review

An independent review of the Nursing and Midwifery Council's (NMC) culture has highlighted safeguarding concerns and found that employees have experienced racism, discrimination and bullying. The NMC commissioned the review after concerns were raised

about the organisation’s culture, including racism and fear of speaking up. Over 1,000 current and former NMC colleagues, plus more than 200 panel members who sit on fitness to practise hearings, shared their lived experiences as part of the review. The report also highlights suicides by nurses subject to delayed fitness to practise investigations, with some nurses under investigation for nearly 10 years. A backlog of 6,000 cases has meant some nurses waiting four or five years for their investigation to be completed, regardless of the severity of the complaint. The NMC has accepted the report’s recommendations.

James Duncan
Chief Executive
September 2024

NHS
North East and North Cumbria

ICB Quality Strategy

David Purdue

Quality Strategy headlines

Quality strategy underpins our ICB strategy, Better health and wellbeing for all

Link between health inequalities and avoidable harm

Five strategic themes to enable us, as a system to continue to improve and be ‘the best at getting better’

Culture and Climate are key

Focus on what it means for our citizens and what it means for our system

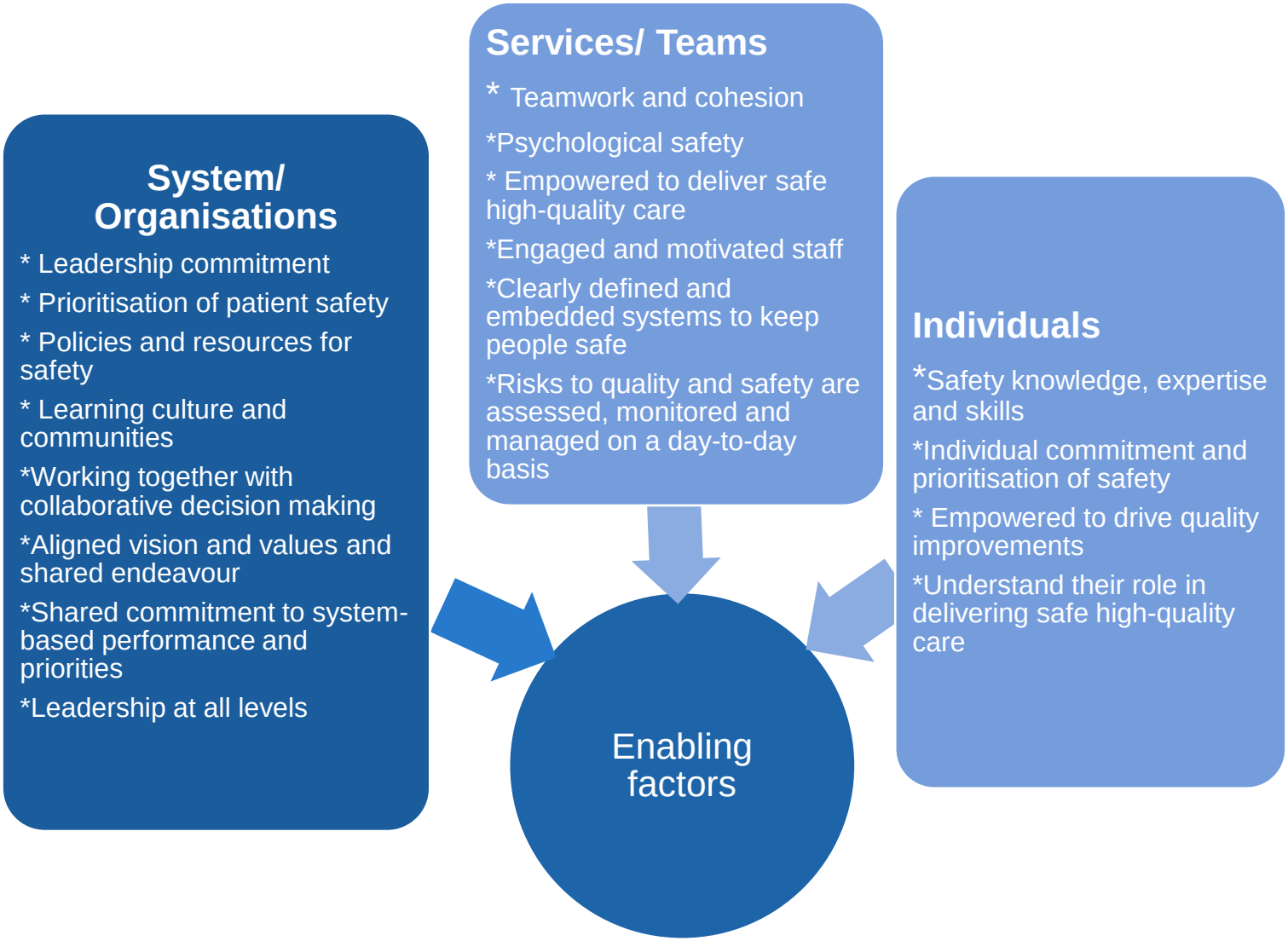
Working together across the system

Our Strategic Themes

Culture and Climate

- Culture matters
- Safety and high-quality care needs to be a priority for all
- Enabling factors and enacting behaviours that will help us to build a safer culture
- We will adopt the following principles:-
  - Professional Curiosity
  - Just Culture
  - Freedom to speak up
  - NHS People promise
  - Equality, diversity and inclusion
- Tackle closed cultures

Creating the culture



I/ we statements- enhancing people's experience of care

I statements:

- help people understand what a good experience of care looks and feels like
- They reflect on what people say matters to them

We statements:

- highlight the collective efforts of individuals, teams, services, organisations and the system in fostering a culture of unity, mutual respect, and shared responsibility in delivering high-quality care.
- From a CQC perspective; the standards against which they hold providers, LA's and ICSs to account

‘I’ statement: When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.

‘We/quality’ statement: We work in partnership with others to establish and maintain safe systems of care in which people's safety is managed, monitored and assured, especially when they move between different services.

Patient Safety

Patient safety

- Safety is a priority for everyone with a clear commitment to improve safety.
- We will embed processes and systems across the ICS that promotes high quality, safe and effective care.
- We foster a culture of openness, transparency and learning to improve safety for people.
- Care across the system is delivered in a way that minimises things going wrong and maximises things going right.
- We will recognise and celebrate outstanding health and care so we can learn when things go well and when things have not gone well.
- We identify risks and use these as an opportunity to put things right, learn and improve.
- We will consider the impact of health inequalities on patient safety and identify actions that reduce the risks of harm.

What this means to our citizens

- I feel safe and am supported to understand and manage any risks.
- If something goes wrong, I will be supported in an open and honest way and will receive an apology.
- I understand the service recognises when things haven't gone well and uses these to improve the service.
- I am cared for by staff who have the skills and experience to support me.
- I am empowered to be a partner in my care and staff understand my individual needs that promotes my safety.
- I know staff understand my specific needs and vulnerabilities; they tailor care that promotes and delivers better outcomes for me, and that reduces the risk of avoidable harm.

What this means for the system

- We have a culture of safety and learning where staff can raise concerns, these are investigated and learning opportunities are identified.
- There is an environment where we can share learning across organisational boundaries.
- We can demonstrate improvements have been driven across the system that improves people experiences of care, reduces variation and health inequalities.
- We deliver care to meet the individual needs of people, that improves outcomes by reducing disadvantage and the risks of avoidable harm.
- We have encompassed human factors to underpin our approach to patient safety and quality improvement.
- The approach to the patient safety incident response framework across the system has been embedded.
- We have established and developed our communities of practice.
- Staff understand their role and responsibilities in delivering safe care and contributing to quality improvements.

Clinical Effectiveness

Clinical Effectiveness

- Across the system people receive the right care, at the right time, in the right place.
- We will adopt and share evidence-based practices to the care and treatment people receive.
- We will use data and intelligence to drive improvements to ensure effective high-quality care.
- We will measure and publish quality-measuring what matters to people, monitoring quality and safety consistently and use data to inform decision-making.
- We will set clear standards for what high quality care and outcomes look like based on what matters to people and communities.
- We ensure there's co-ordination of services across the system, that considers the needs and preferences of different people, including those with protected characteristics and those at most risk of a poorer experience of care.
- We are alert and responsive to health inequalities, and social determinants of health which may lead to poorer outcomes and premature deaths.

What this means to our citizens

- I have care and support that is co-ordinated, and everyone works well together and with me.
- I am empowered to get the care, support and treatment that I need.
- I know my care is the most effective it can be and is in line with recognised standards.
- I know the services that care for me, are working together to ensure I receive high quality care.
- When I move between services, there is a plan for what happens next, and all the arrangements are in place.

What this means for the system

- We have systems to use data, intelligence and knowledge to inform our decision making.
- Our clinical conditions strategic plans are improving outcomes for people and reducing variation and health inequalities.
- We are staying ahead by embedding research and adopting innovation to ensure progressive high-quality care across the system.
- We have a quality improvement methodology to support our improvement work across the system.
- We design services to meet the needs of our diverse population by promoting equitable access, excellent experience and better outcomes for all, that reduce disadvantage, and the risks of avoidable harm.
- Staff keep up to date with best practice, by delivering care that optimises people's health and improves patient experience and outcomes.

Positive Experiences

Positive Experiences

- We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support.
- We involve people in decisions about their care and tell them what's changed as a result.
- We actively seek out and listen to information about people who are most likely to experience inequalities in experience or outcomes.
- Services across the system are designed by what matters to people, that empowers them to make informed choices and is delivered with compassion, dignity and respect.
- We will co-produce with people with 'lived-experience' as they are often best placed to advise on what support and services will make a positive difference to their lives

What this means to our citizens

- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals.
- I am supported to manage my health in a way that makes sense to me.
- I am involved in decisions about my care.
- My feedback was taken seriously, and I know what changes have been made as a result.
- I felt that my voice was heard and that I was listened to and understood.
- I am encouraged and enabled to feedback about my care in ways that work for me, and I know how it was acted on.
- My individual needs and preferences are understood, and these are reflected in my care, treatment and support, and takes account of my personal, cultural, social and religious needs.

What this means for the system

- We listen to people's views and experiences, and they are seen as an integral part of our quality improvement work.
- We use people's experiences as a central component to quality assurance and identification of risk.
- We recognise people's experience could be early warning signs of poor care.
- We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
- Our patient and public involvement strategies are embedded into our work across the system.
- Staff understand their role in supporting and empowering people to make informed decisions about their care.

Clinical and Multi-Professional Leadership

Clinical and Multi-Professional Leadership

- We will be driven by collective and compassionate leadership which champions a shared vision, values, and learning, delivered by accountable organisations and systems.
- We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of the system.
- Clinical and care professionals are involved in all aspects and every level of system decision-making.
- We have a transparent approach to identify and recruit leaders that promotes equity of opportunity, that also recognises the different kinds of leadership styles required, when working across professional and organisational boundaries.

What this means to our citizens

- When I receive care, services meet my needs and that of the wider community, and all leaders and staff support this.
- I will be involved in designing services and my feedback is heard and valued by leaders in the system.
- I am confident leaders and staff are able to identify poor care and address this quickly.
- I know that staff and leaders with the right skills and experience are making decisions about care services.

What this means for the system

- We have high-quality leadership throughout the system which is sustained through safe, effective and inclusive recruitment and succession planning.
- Our leaders are skilled and confident and can contribute effectively to quality improvement.
- We are alert to examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff and our leaders address this quickly.
- We have embedded leadership strategies and development opportunities within the system.
- Leadership is front and centre of system and service delivery; all staff understand their role and contributions to delivering high quality care.

Working together to deliver Quality

How we will do this together?

As an ICB and commissioner

- Set clear quality standards and expected outcomes when commissioning as part of quality and performance management.
- Developed the system as the 'best at getting better' with established communities of practice.
- Have clear governance frameworks for quality.
- Quality assurance gives a clear and accurate picture of safety, and there are steady improvements in safety over time.
- Develop a positive safety culture that is embedded at all levels of the system.
- Work together across the system to ensure seamless pathways between services that focus on delivery of high-quality care.
- To co-produce with communities to shape services to meet their needs.
- Share learning, best practice, and innovations across the system to influence and improve the quality of services.
- We have consistency in approaches which leads to more standardised practices in services.

For people and communities

- People in our communities know what good care looks like, what they have a right to expect, and what to do when their experience doesn't meet expectations.
- People are partners in their care and are supported in making decisions about the care they want to receive.
- People have care that is personalised, and they are treated with dignity and respect.
- People's voices are heard, listened to, and understood and feedback is used to drive improvements in quality.
- People are included in reviews and contribute to improvements in care.

For all health and care providers

- Experience a coherent system of quality assurance and performance management.
- Are accountable for the quality of care they provide, and driving quality improvements which translates into improved health outcomes.
- Care is co-ordinated across services, organisations and the system and they work collaboratively to meet people's needs.
- Support the system to continually improve and maintain quality and safety standards.
- Work as system partners and understand their role in improving health outcomes, reducing variation and health inequalities.

For all staff

- Staff are seen as partners in delivering safe high-quality care,
- Staff feel safe and confident to speak up without fear of retribution.
- Staff are supported to learn and make improvements to care at every level of the system.
- Staff are engaged and motivated to develop and drive improvement plans.
- Staff are supported to learn and develop to embed quality and safety practices in their everyday work.

Our Quality Strategy foundations and next steps

Culture and Climate

Strategic theme

Culture and climate

Foundations

*Established FTSU processes across the ICB
*ICB assessment of FTSU processes in NHS trusts
*Adoption and implementation of NHS People promise/ Just culture.
*Quality assurance tools developed for some services with specific prompts around closed cultures.
*Recognise the need for clear values and behaviours both within the ICB and across the system
*Closed cultures highlighted as a strategic quality priority.
*Intelligence sharing between stakeholders

Next steps

*Clear set of values and behaviours for the ICB as an organisation and the wider system.
*Review of tools for both commissioning and quality assurance to ensure they include key culture prompts.
*Staff at all levels, regardless of role understand their roles and responsibilities.
*Learning packages about culture/ closed cultures for all staff in the system.
*Staff at all levels understand the inherent risk factors and warning signs of a closed culture.
*Cultural assessment of the system against the 37 features of an open culture and develop culture metrics .
*Develop system wide plan to tackle closed cultures.

Patient Safety

Strategic theme

Patient Safety

Foundations

*Concept developed for our patient safety centre.
*Development and implementation of the ICB PSIRF policy and approach. This includes:-
*Support to organisations and sign off PSIRP plans,
*Training and development including raising awareness, patient safety specialist training and patient safety partner identified and agreed.
*System wide never event deep dive
*System approach identified to the implementation of Martha's rule.
*Data and intelligence monitoring information available for the ICB.

Next steps

*Launch of our patient safety centre in September 2024; the centre will be our focal point to drive patient safety improvements.
*Develop the ICB and system wide patient safety framework.
*Roll out of PSIRF training for all staff, existing patient safety specialists to complete training, approval of the model for patient safety specialists, and learning support specialists.
*Specific learning and improvement sessions starting with never events and sepsis.
*Development and embedding communities of practice.
*Patient safety improvement plans developed, identified by people's experience, data and intelligence.
*Further enhancements to data and intelligence monitoring to incorporate people's experiences.
*Enhance routine reporting requirements for all commissioned services as part of contracts.

Clinical Effectiveness

Strategic theme

Clinical Effectiveness

Foundations

*Clinical conditions strategic plans for adults and children developed.
* NENC healthy and fairer programme including:- prevention, health inequalities and broader social and economic determinants.
* Part of CQC stakeholder forum for the development of the health inequalities self-assessment.
*Women's health conference/ collaborative
*Development of clinical effectiveness committee within the ICB
*Medicine optimisations
*Monitoring of mortality themes and trends.
*Quality improvement methodology approach being developed.

Next steps

*Launch our clinical conditions strategic plans with monitoring of progress.
*Programmes from healthy and fairer including :- tobacco, CORE20PLUS5, and poverty proofing.
*Women's health innovation conference July 2024
* Quality improvement methodology developed and used as part of our quality improvement work

Positive Experiences

Strategic theme

Positive Experiences

Foundations

*Patient and public engagement ongoing work
*Healthwatch- programme of activities
*ICB- complaints management
*Ongoing monitoring of patient experience surveys including CQC.
*Work with voluntary sector groups
*Assessment tool developed to assess the quality of provider complaints systems.
*National learning from the resuscitation council on outcomes for people in our communities.
*In response to patient feedback, identified a need for further work to support those waiting for a CAMHS appointment.

Next steps

*Continue to gather and learn from people's experiences to improve quality of care
*Quality of complaints to be part of quality assurance framework for commissioned services.
*Roll out of restart a heart campaign to targeted groups/ places to tackle health inequalities.
*Develop a practical waiting well approach to support people waiting for CAMHS.

Clinical and Multi-Professional Leadership

Strategic theme

Clinical and Multi-Professional Leadership

Foundations

*Clinical and Multi-professional leadership framework developed.
*System leadership group established across the system.
*Senior leaders meetings/ forums within ICB
*Clinical and Multi-professional leadership framework - wider engagement to take place on the framework.
Boost our learning community offers leadership development to be effective convenors of system change.
*AHP council established

Next steps

*Clinical and Multi-professional leadership framework - wider engagement to take place on the framework.
*Self-assessment/ gap analysis to be undertaken.
*Decision making map to be developed - to show how clinical leaders are involved in every level of decision making.
*Learning and development needs to be reviewed- including generic and profession specific.
*System leadership development at every level.

Quality Governance framework

Quality Governance framework

Foundations

*Quality assurance and monitoring; developing a consistent approach across the ICB- pilot tools developed.
*Standardised tool developed to support assessment of complex care caseload and responsive safety assessment tool.
*System Equality and Quality Impact assessment policy developed including equality and health inequalities- pilot of tool being undertaken.
*Internal audit in relation to governance of commissioned services.
*Independent investigation reports reviewed, and thematic analysis completed of ICB recommendations.
*Some policies identified as requiring updating- tools developed and process established to review all ICB policies.
*Incidents and risk registers- gaps in assurance identified.
*Quality governance meeting proposal developed- engagement started.

Next steps

*Quality assurance and monitoring of commissioned services; developing a consistent approach across the ICB- programme to develop tools for all service types.
*Independent reviews- Key themes identified and plan to be developed to identify actions/ action owners.
*Training and development for all staff about governance.
*Overarching improvement plan linked to audit plan to improve quality governance arrangements and how this correlates with corporate governance.
*NHSE ICS quality functions- Self-assessment tool developed to assess our compliance with the quality functions, this needs to be undertaken.
*Self-assessment against CQC standards- tool to be developed for Key ICS quality statements and also CQC well-led framework for NHS trusts.

2. STRATEGIC AMBITION 1 - QUALITY CARE, EVERY DAY

Darren Best, Chair

2.1 QUALITY AND PERFORMANCE COMMITTEE REPORT

Louise Nelson, Committee Chair

REFERENCES

Only PDFs are attached

2.1 QP Committee Assurance Report 31st July 2024.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Wednesday 4th September 2024

Name of Board Committee	Quality and Performance Committee
Date of Committee meeting held	31 July 2024
Agenda items/topics considered	See Appendix A
Date of next Committee meeting	25 September 2024

1. Chair's summary

Quality Focus: Crisis referrals. Chloe Mann, Place Director, Community Care Group, North presented an overview of the current service provision, performance and activity data, details relating to the improvement programme and its associated workstreams, what 'success' looks like and Your Voice feedback.

It was noted the variation in referral numbers across the CNTW footprint and reference to the national standards on crisis response rates. It was noted that there had been an increase in negative responses through Your Voice which related to the increased numbers of calls coming through the service and Your Voice providing a much easier mechanism to provide feedback. Clarity was sought from the members around the NHS select Mental Health option and impact of CNTW with assurance given that many of those calls aren't seen by CNTW but signposted to other support services.

Assurance was noted from Q&P of service user and carer involvement in the various working groups and the actions currently underway to address the demand for services and the positive update.

Health & Safety Executive

The committee received an update on the Improvement Notice previously issued to the Trust by the HSE. The trust submitted its response to the Improvement Notice on 3rd May 2024, and the HSE had subsequently responded to request that some areas within the trust's response are strengthened, particularly relating to:

- Policies and associated PGNs need to be strengthened to include reference to violence and aggression risks posed by patients to staff – this has since been actioned.
- The HSE Could not see any evidence that front line staff had been involved in risk assessments, i.e. feeding in their experiences.

Clinical Risk Assessment of Patient Specific Risks in MDTs needs to also focus on staff as the HSE Inspector felt there appears to be nothing on reducing risk to staff

It was noted that the newly established Violence Reduction Steering Group – which, following discussion at the Trustwide Safety Group (TSG), will become a formal part of the governance structure meeting bi-monthly.

Integrated Performance Report (IPR)

Highlights from the IPR:

- FFT performance has improved to 85.7% in June which is comparable with the national score of 85%;
- Clinical supervision performance has improved during quarter 1 and this continues to be a significant area of focus. It is anticipated compliance will have been achieved within Learning Disabilities and Autism by the end of September 2024;
- Violence and aggression incidents remain a significant area of focus with regular reviews of care plans and care delivery approaches being undertaken together with risk assessments on the areas identified as hot spots;
- There has been a marked improvement in the biopsychosocial risk assessment compliance following its introduction in early April;
- There has been a focus, within the Inpatient and Specialist Care Groups, on the reading of rights and capacity at the point of detention;
- There were no inappropriate out of area bed days during June;
- Clinically ready for discharge remains a concern within all inpatient areas and place based areas. There were up to 60 clinically ready for discharge patients within the patch until very recently and collaborative work is underway with the ICB and Local
- Authorities to address this issue;
- At Month 3 the trust has generated a £6.4m deficit which is in line with the Month 3 plan. At the end of Month 3 agency spend was £2.6m against a plan of 2.7m.

Community Services Waiting Times Update

Highlights noted:

<u>Children and Young People Services (CYPS)</u>

- 94% of the 5,881 CYPS waiting longer than 4 weeks (as of June 2024) are on a Neurodevelopmental pathway. Of those waiting over 4 weeks, 3,760 are undiagnosed at this point in time. 567 referrals have waited longer than 2 years.
- The Community Services Oversight meeting continues to meet on a weekly basis to look at waiting list management and discuss potential areas of recovery
- The CYPS redesigned neuro developmental pathway has been agreed by the Executive Management Group – this will be aligned to the work underway via the ICS

<u>Working Age and Older Adults</u>

- There are 1,769 working age adult patients waiting longer than 4 weeks for Treatment as of June 2024, down from 3,051 in July 2023.

- There are 390 older adult patients waiting longer than 4 weeks as of June 2024, this has improved from 843 waiting more than 4 weeks in July 2023.

Adult ADHD

- There are currently circa 12,000 patients waiting assessment for Adult ADHD and this trend is increasing month on month.
- The average wait to be assessed for adult ADHD (if joining the waiting list in February 2024) is 7 years.

It was noted that the adult ADHD waiting list was highlighted at the ICB Public Board meeting on 30th July by a Local Authority colleague and there was a reflection that whilst the issue has been discussed widely, limited progress has been made. The ICB CEO made a plea that partners look into identifiable actions that will make a difference and a meeting has been arranged to discuss this issue further.

Safer Staffing Report

- Work is in progress to enhance the accessibility of the care hours per patient day information by including contextual information including turnover, vacancy, sickness and temporary staffing usage information which will be included in future reports.
- The latest Mental Health Optimal Staffing Tool (MHOST) exercise has been completed and the information will be collated to inform the staffing skill mix review which will be presented at the September Committee.
- Newly registered nurse recruitment for nurses who quality in September 2024 has been completed and focussed work is underway in relation to retention.

Q&P noted the ongoing improvements to the report

CQC

Must Do Update report – the Committee approved a short extension to the action timescales relating to debriefs, body maps and physical health/rapid tranquilisation and explained that this is to allow some further time for the intensive pieces of work in these areas to continue.

The Committee also approved the closure of the Clinical Supervision action plan.

The Committee were advised that the CQC undertook an unannounced inspection on Learning Disability and Autism wards during week commencing 15th July 2024.

Quality & Safety Report

The Committee received the first iteration of the Trustwide Quality and Safety Report (which replaces the previous Safer Care Report), highlighting that the aim of the report will change each time to ensure that safety data aligns, where necessary, to PSIRF aims and objectives. Your Voice feedback data from Service Users and Carers will also be incorporated into future reports

Committee Members were asked to digest the report and feed any comments.

Additional Reports Received

IPC BAF & IPC Annual Report
CNTW Pandemic Plan
Research & Development Annual Report
Service User & Carer Experience Report
Positive & safe Annual Report

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

Discussions are underway in relation to incidents that do not meet the threshold for a more detailed investigation in terms of identifying any learning themes. A discussion will take place at a future meeting in relation to how the Committee can be assured that learning is happening (and is appropriate) and what the confidence is around some of the incidents which have not reached the threshold for further investigation

There are currently circa 12,000 patients waiting assessment for Adult ADHD and this trend is increasing month on month

Capacity, consent and rights

3. Key challenges now and in the medium term

Recommendations and considerations following the recent unannounced CQC Inspection

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

The topics to be agreed for the Quality Focus to be agreed

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

Community services, waiting lists and activity.

8. Review of Board Assurance Framework and amendments thereon

Committee reviewed the BAF with the most significant risk for the Committee in relation to the demand and access to services. Corporate Risk 2508 which relates to GPs handing back medication management to community teams was discussed and the outcome of the GP ballot and the potential impact of this on the trust's services is something the Committee should be aware of.

Colleagues agreed that one of the main areas of concern and discussion at the Committee has been around community services, waiting lists and activity.

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.

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

22nd August 20204

Sarah Rushbrooke
Executive Director of Nursing Therapies and Quality Assurance

2.2 MENTAL HEALTH LEGISLATION COMMITTEE REPORT

Michael Robinson, Committee Chair

REFERENCES

Only PDFs are attached

2.2 MHLC - Board Committee Assurance Report September.pdf

Board Committee Assurance Report
Board of Directors
Wednesday 4th September 2024

Name of Board Committee	**Mental Health Legislation Committee (MHLC)**
Date of Committee meeting held	7 August 2024
Agenda items/topics considered	See below
Date of next Committee meeting	6 November 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 although no formal feedback had yet been received. In relation to feedback received from previous visits, action plans are in place to meet the issues raised following those visits and the issues raised 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 continues to monitor detentions under the MHA in all its regions through the Mental Health Legislation Steering Group (MHLSG) to compare with national trends and data and to conform with the Patient and Carer Race Equality Framework (PCREF).
- The Trust is required by PCREF to monitor detention by ethnicity of service users and the necessary processes are in place to comply with these obligations as are those to develop the CNTW PCREF Plan and to produce a Health Inequalities Annual Report. This area will continue to be reviewed by the MHLSG.
- The Committee received the further results of a review of panel membership and practices including a consideration of the practices of other Trusts in this area in relation to appraisal of panel members. The Committee will review and recommend training and appraisal processes for panel members on the basis of that review and further work being undertaken by MHLSG.
- The MHLSG continues to monitor compliance with the completion of Parts A and B of local forms on Rio. Local groups are urged to look for ways to improve compliance and to report to MHLSG on the steps taken at a local level. The Committee will continue to monitor this area and seek signs of increased compliance.

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 and consent under Parts A and B of local forms</u>
Whilst there continues to be a low compliance rate in the completion of the local forms, the forms have been reviewed and amended as appropriate to make completion more straightforward and to ensure that they are user friendly and capture the relevant information. 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. MHLSG has asked local groups to report on steps taken to improve compliance at its next meeting and those steps will continue to be monitored by MHLSG. The Committee and the Quality and Performance Committee of the Board will continue to monitor this area for signs of improvement in compliance

Mental Health Legislation Training
Most recent data indicates that compliance with MHL training is at 75.2% of the workforce. Whilst there has been a consistent improvement in compliance rates in recent months, this is still below the target set. 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.

3. Key challenges now and in the medium term

With the changes in Government, the timetable for legislative scrutiny and enactment of the Mental Health Bill is unclear. However, in the Kings Speech it was made clear that this is a priority for the new Government and therefore it is likely that a timetable for review and enactment will emerge in the relatively short term Any 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.

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 will offer a hybrid approach to hospital managers hearings from 1 September 2024. 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 training package is available via the Trust intranet. The rights training package provides vital information to our professionals to ensure compliance with the MHA Code of Practice and includes a relevant quiz.

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

After recent recruitment, there are currently [51] panel members sitting with a further [10] new members about to commence their induction process. 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. [2] of those prospective members about to commence the induction process are from minority ethnic communities. The Committee will continue to monitor this area and encourage recruitment from these groups. 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. The MHL department is working with the MHLSG to identify the preferred approach to training and appraisal and will report to the next meeting of the Committee. will continue its review and report to the Committee on the appropriate training and appraisal process.

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 recommendations of the MHL Department and MHLSG following the review of panel membership, training and appraisal.

Following the update received by the Committee on detentions and PCREF, the Committee will continue to monitor detentions and seek comparators from other areas and Trusts.

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

The Committee would draw the attention of the Board to the work being done to improve compliance with Parts A and B of local forms and assure the Board that it will continue to review this area and seek improvements.

The Committee previously drew the attention of the Board to the decision of the Employment Appeal Tribunal in Lancashire and South Cumbria NHS Foundation Trust v Ms R Moon which determined that panel members may be afforded certain employment rights arising from their role. The MHL legal team is in discussion with other Trusts as to the possible implications of this decision and the implications for the Trust.

The Committee would also draw attention to the further work on panel membership, detention numbers and ethnicity data referred to at 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: 7th August 2024

Dr Rajesh Nadkarni
Medical Director & Deputy Chief Executive
Date: 7th August 2024

2.3 LEARNING FROM THE SHANLEY REPORT AND CQC REVIEW OF MENTAL HEALTH SERVICES AT NOTTINGHAM HEALTHCARE NHS FT

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

PRESENTATION

REFERENCES

Only PDFs are attached

2.3 Shanley Report and Nottinghamshire Board September 2024 Team engine version.pdf

Learning from Edenfield Greater Manchester NHS Foundation Trust

Independent Review of Greater Manchester Mental Health NHS Foundation Trust

Final Report, January 2024

Dr Rajesh Nadkarni
Deputy Chief Executive and Medical Director, CNTW

Undercover Hospital: Patients at Risk

A Panorama undercover investigation has found evidence that a secure NHS psychiatric hospital is failing to protect some of its vulnerable patients. Secret filming reveals evidence of a toxic staff culture, patients being taunted and bullied, inappropriate use of restraint and falsification of important medical paperwork. Experts who have reviewed the findings have questioned the hospital's safety, saying the evidence suggests its core therapeutic mission is being corrupted.

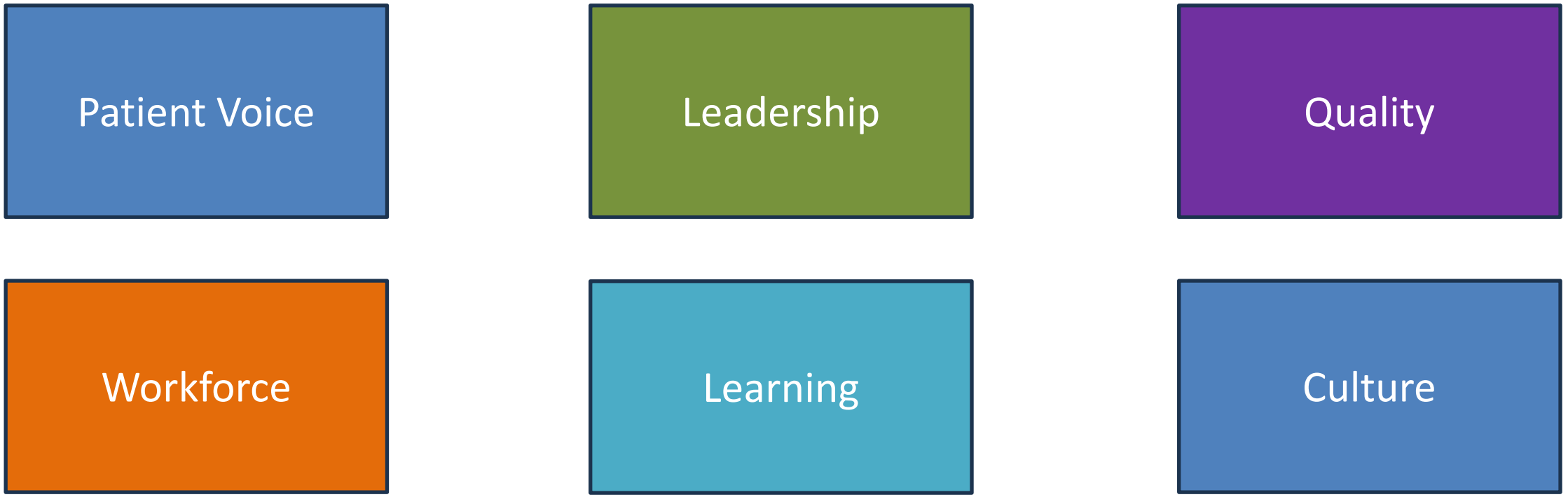
Show less

28 September 2022
59 minutes

The NHS and how we learn?

- Some patients and families described **not being believed when they raised concerns** or complained about the care received. We were told that they sometimes **experienced unkindness, a lack of compassion and respect, and abuse by staff.**
- Others shared how **they did not always feel safe to disclose concerns**, with many accounts of feeling **intimidated, undermined, ignored, or fearful** that 'bad news' was not welcomed.
- **Insufficient oversight on quality of care and a failure to learn.**
- **Disproportionate reliance** on views of **external regulators**.
- **Missed opportunities** in spite of information available with a range of regulators and professional bodies.
- Workforce challenges, **staff feeling exasperated, tired** of not being listened to and **disconnected from Trust leadership** leading to staff leaving the organisation.
- **A culture of bullying and harassment and poor team work.**


Reading the signals
Maternity and neonatal services in East Kent – the Report of the Independent Investigation
Dr Bill Kirkup CBE



What do we see and what does it feel like

Recommendation 1: The Trust must ensure that **patient, family and carer voices** are heard at every level of the organisation. The Trust must **respond quickly when people experience difficulties** with the services they receive and make lived experience voices central to the design, delivery and governance of its services.

Current Review ongoing of the nature of patient/carer and family involvement in our inpatient, community and specialist areas.

To feed into the TLF session on patient voice, engagement and involvement.

Recommendation 2: **A strong clinical voice** must be developed and then heard and championed from Board to floor, and in wider system meetings.

Development of Clinical/collective leadership programme.

Review and strengthening of Clinical Networks.

Recommendation 3: The Board must develop and **lead a culture** that places quality of care as its utmost priority, which is **underpinned by compassionate leadership** from Board to floor. This culture must ensure that **no staff experience discrimination**.

Ongoing work in relation to the Leadership and Healthy Culture work led by the Executive Team and influenced by TLF.

Ongoing work in relation to EDI and Inclusion.

Recommendation 4: The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, including ensuring the **stability of nursing** staff. The Trust must develop a **representative, competent and culturally sensitive workforce** which is supported to provide services that meet the needs of its communities.

Ongoing work in relation to workforce plan, and inpatient staffing model.

Recommendation 5: The Trust needs to have a better understanding of the **quality of its estate** and the impact of this on the delivery of high-quality care, including **providing a safe environment**. It must ensure that **essential maintenance** is identified and carried out in a timely manner and that the cleanliness of units is maintained.

Managed through NTW Solutions and through oversight from TSG and EMG.

Recommendation 6: The Trust must ensure that its **governance structure** (and the culture that this is applied within) supports timely escalation and that the right information can be used at the right level, by the right staff. There must be much greater focus on the **validation and triangulation of information** to ensure that quality issues can be resolved quickly and learning can take place.

Governance review which consolidated the Decision making and Assurance and Risk Management functions.

Development of Cultures Dashboard and Oversight of the IPR.

Recommendation 7: The Trust must ensure that Edenfield provides **compassionate**, high-quality care and that **all staff**, permanent or temporary, have the skills, knowledge, and **support to achieve this**.

Secure Care Services to review.

Summary of Actions Taken by CNTW

- TLF session on patient voice, engagement and involvement led by Sarah Rushbrooke.
- Development of Clinical/collective leadership programme led by Executive Team.
- Review and strengthening of Clinical Networks led by Ramona Duguid.
- Leadership and Healthy Culture work led by the Executive Team and influenced by TLF.
- EDI and Inclusion work led by Lynne Shaw.
- Ongoing work in relation to workforce plan, and inpatient staffing model supported by the Executive Team.
- NTW Solutions management of estate quality and patient related safety issues with oversight from TSG and EMG.
- Governance review which consolidated the Decision making and Assurance and Risk Management functions.
- Development of Cultures Dashboard and Oversight of the IPR.
- Secure Care Services to review skills and competencies of the work force.

Looking at this live – dashboard development

- Patient carer voice
- Workforce
- Quality
- Staff voice
- Environment
- Speaking up culture

CQC Rapid Review Nottinghamshire

3 Enduring Areas of Concern

Demand for services and Access to Care

- Waiting lists
- Access to Beds

Staffing

- Complex staffing arrangements in community services
- Approach to risk assessment and management was inconsistent

Leadership

- Changes
- No approach to address safety concerns

Quality of Care

- Care Planning Inconsistent
- Families and Carers not involved
- Treatment not adhering to MHA code or Evidence Based Practice

Recommendations/Observations

- New guidance from RC Psychiatrists to deal with complex psychosis and paranoid schizophrenia
- Address the shortage of mental health staff
- Integration with other services, LA and community and police
- Improving Data

Recommendations/Observations

- Proper Diagnosis (Purposeful Admission)
- Risk Assessment
- Care planning and Engagement with family
- Medicines Management (Depots, NICE etc..)
- Discharge planning (Inpatients to Community)

Relevance for CNTW in relation to Community Mental Health Transformation

- Personalised care and Family Carer involvement
- Integration (All services including police)
- Crisis/EIP and CTT's need to be working closely together especially when it comes to managing Complex psychosis
- Key worker responsibilities for green/orange always with us along with robust MDT decision-making
- Evidence Based Treatments (psychological)
- Medication Management (Depots and Clozapine project rollout)
- People waiting for services
- Learning from Incidents

Action 1: Clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge”

Policies	• CNTW(C)06 Non-Attendance Policy (DNA -Did Not Attend) Was Not Brought (WNB)) • CNTW(C)07 Promoting Engagement With Service Users • PGN - 06 - Allocation and Reallocation of Service Users • CNTW(C)04 Safeguarding Children Policy • CNTW(C)24 Safeguarding Adults at risk
Value, usefulness, benefits of the policies	• Policies above support clinical decision making whether that be in supervision, MDT’s and complex cases. • Provide reassurance to the clinical team when make complex decisions. • The CNTW(C)06 Non-Attendance Policy (DNA -Did Not Attend) Was Not Brought (WNB)) and CNTW(C)07 Promoting Engagement With Service Users policies are promoted to be used together and are used in collaboration with each other.

Action 1- continued: Processes in place

North Cumbria	Northumberland and North Tyneside	Newcastle and Gateshead	Sunderland and South Tyneside
Stop The Line Compass Meetings Complex Case Barriers relating to attendance are discussed in supervision, MDTs and in Complex Case meetings.	The Teams use MDT, Clinical Supervision, caseload supervision to discuss an individual's readiness for discharge. The teams aware of the Promoting Engagement Policy and Trust DNA policy but will make more attempts to engage, consider reasonable adjustments and/or explore any barriers to engagement. The services will use outreach and assertive engagement with patients open to the team, as 3 DNAs could indicate that a patient is relapsing. For assessments, an individual approach is used to DNA's, clinicians explore the circumstances of the referral, risk and communicate with the client, family, carers referrer etc about next steps. All DNAs are discussed within Post Ax feedback/MDT meeting.	The Teams use MDT, complex case discussions as indicated, regular leadership interface and liaison with relevant services. They also hold a leadership forum twice a week that the whole team can attend to identify any current issues and potential problems and solutions. MDT discussions are held daily regarding those we have found difficult to engage, exploring means to encourage engagement and obstacles to same. The Crisis Team leads are often in contact with community teams for those who are under CTT, EIP etc to help with engagement where possible too. Any discharges are discussed within the MDT and we ensure that all means have been explored in attempting engagement i.e. cold calling, contacting family where appropriate.	The Teams do not have a blanket rule on discharge and all complex cases will be engaged in a mixture of methods and discussed in an MDT before any decision to discharge is made. Each Community Team and Op Courage, have a weekly clinical pathway meeting where complex cases are discussed, and discharges agreed. All discharges are discussed in crisis MDT there is a weekly assessments not taken on meeting which discusses referrals that have not been assessed or ones that have DNA or not engaged. We also have a daily 4pm risk review meeting for any patients that have not attended or disengaged in appointments.

Action 1- continued: Challenges and Themes

Challenges	• Some challenges may present when partner agencies are unable to attend MDT Meetings at short notice. However, this is managed individually. • Potentially which agency 'owns/instigates' whether we need to pull everyone from across the system together for a discussion – is this explicit enough in the existing policy for promoting engagement and DNA/not brought policies.
Themes	• All areas have robust processes in place for engagement. • MDT meetings are commonly used to discuss patients and agree actions which may lead to discharge.

Community Care Group – response to CQC rapid review (Nottingham)

- In line with the CQC rapid review (Nottingham), the Community Care Group will work with the Trust Innovations Team to devise a rapid audit tool focusing on the priority areas in the review.
- We will review the audit results to establish compliance as per guidance documents.
- Any gaps across all place areas will be highlighted, understood and actioned.
- We will audit caseloads ensuring they are independent to eradicate any potential bias.

Guidance to ICBs on intensive and assertive community mental health care NHSE 2024

Key messages

Services have a duty to engage with people with SMI and their families/carers

Lack of engagement may be a result of the service offer not being what they want or need; reflective of previous poor treatment; a lack of cultural relevance/understanding; the individual not recognising that they are unwell and need treatment.

Intensive and assertive community care requires dedicated staff

Systems have a responsibility to ensure they commission the right mix of services to support the needs of their local populations. This includes a dedicated resource to provide intensive and assertive care for those individuals wo need it.

'No wrong door' approach

Community mental health services should be operating a 'no wrong door' approach and be well joined up with other statutory services and Voluntary Community Social Enterprise (VCSE) partners to identify people who might require intensive and assertive care and who are less likely to present via standard routes

Continuity of care is vital

An appropriately experienced and competent key worker needs to be in place for individuals; someone who knows the person well and their history to avoid missed red flags and to respond to signs of relapse.

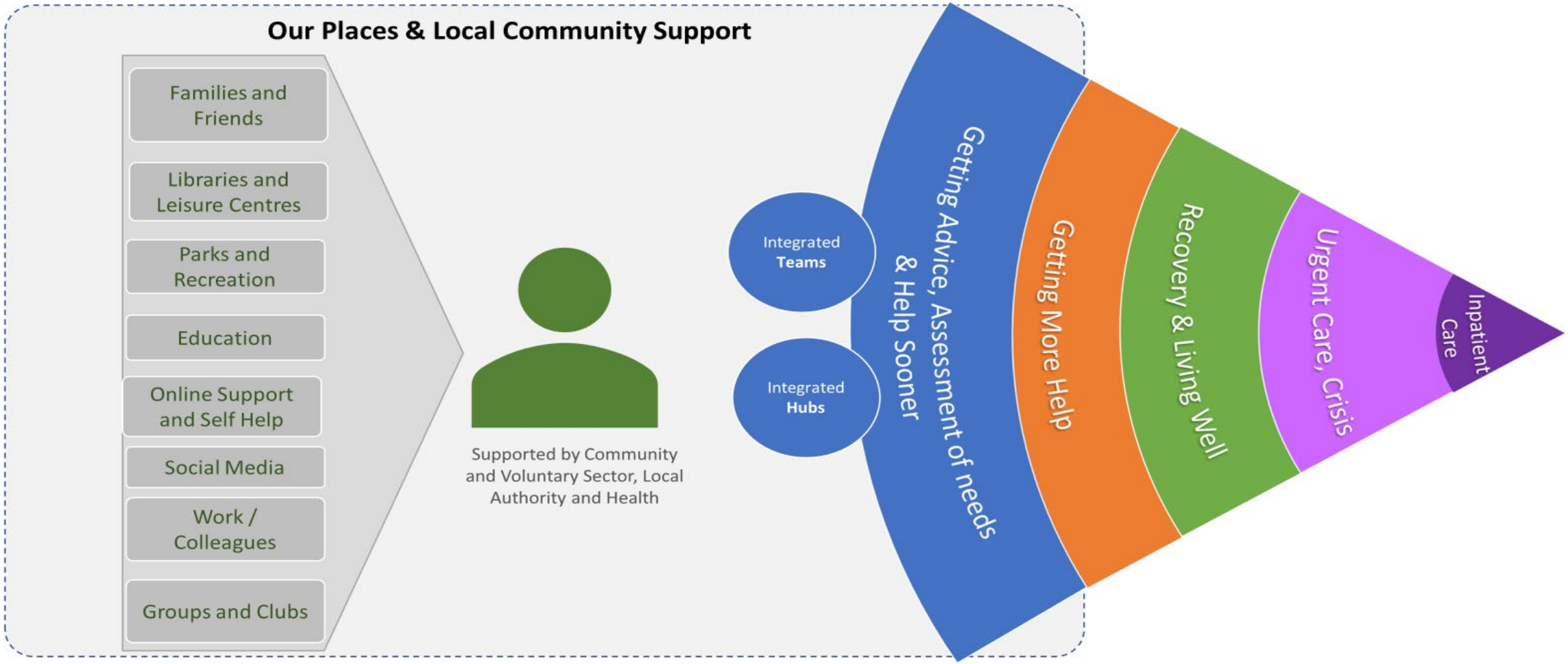
Holistic and engaging care

Services should provide care that is holistic, engaging and trauma informed – helping people with the things that matter to them and using biopsychosocial formulation-based approaches to meet those needs and promote personal recovery (including substance use, finances, housing, etc.)

Guidance to ICBs on intensive and assertive community mental health key service features

1. Access to dedicated and qualified staff
2. Extended hours operation
3. Time unlimited
4. Small caseload
5. Manages stepping up and down of care
6. Identification of individuals in need of intensive community treatment
7. Assertive engagement of individuals
8. Collating and sharing information
9. Care and safety planning
10. Safety / harm management
11. Coordination of care

Our Model of Care



New 24/7 Hub opens in Cumbria

2.4 INTEGRATED PERFORMANCE REPORT ? QUALITY CARE, EVERY DAY

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

Please note this report incorporates various parts of the agenda and will be used to discuss further items relating to:
Item 3.2
Item 4.2
Item 5.3

REFERENCES

Only PDFs are attached

2.4 BoD Cover Sheet - IPR - Month 4.pdf

2.4 Trust IPR - July 2024 - Final.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 4th September 2024**
Title of report	**Integrated Performance Report (July-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	
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	19/08/24
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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

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

SA1 Quality care, every day – We want to deliver expert, compassionate, person-led care
BAF Risk 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. SA1
BAF Risk 2511 – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. SA1
BAF Risk 2512 – Risk of failing to maintain a positive safety learning culture resulting in avoidable harm, poor systems, process and policy, and identification of serious issues of concern. SA1

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 2540 - Risk of increased staffing costs from use of temporary staff impacting on quality of care and financial sustainability. SA3
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

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2024-25 Month 4 (July 2024)

With YOU in mind

Integrated Performance Report - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

- **Training (All Staff courses)** – 3 of the 10 prioritised 'all staff' training courses are close to target. 7 of the 10 are on target
- **Sickness** – 6.4% against a target of 5%
- **Appraisal rate** – Improved in the month to 76.7% (75.1% in June) against a target of 85%
- **Clinical Supervision** – off 80% target at 66.2% although current performance as at 28/08/24, excluding exemptions, is 78.7%
- **Prone Restraints** – There have been significant reductions from levels at 100 a month 12 months ago. However, there has been an uptick from 17 in June to 48 in July due to two patients on two wards (Mitford 1&2 and Riding) accounting for 30 of the 48 incidents.
- **Assaults on Patients** – Increased in the month. 51% involved no physical harm and 48% was due to low physical harm. 1% (1 patient) with moderately physical harm
- **% of patients with a Risk Plan** – off 100% target at 80.2%
- **Reducing Incidents of self-harm –** Significant increase in the month. 99% were low or no physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm.
- **Record of Capacity/Consent to Treatment (CTT) at point of detention**– is consistently off target remaining 33.6% below target
- **Out of Area Placement Bed Days -** 2 inappropriate placements at the end of the month. Although still on target these are the first since December 2023. This is due to current bed pressures within mainly female Adult Acute MH beds and Older Persons.
- **Bed occupancy –** remains off target despite improving in the month.
- **Clinically Ready for Discharge** – remains off target, no significant change. Most patients are waiting for external packages of, housing and care homes places.
- **Adult inpatients discharged with LOS >60 days** – remains off target
- **Crisis Very Urgent Referrals seen within 4 hours –** At 29.3%, the lowest reported performance since February 23 with significant deterioration in the month (43.6% in June).
- **4wks Referral to Treatment - Adult and Older Adult** – 34.4% of referrals have been waiting 4 weeks or less to treatment.
- **4wks to Referral to Receive Help - All CYPS** – 8.4% of referrals waiting 4 weeks to receive help. Overall, a total of (5,953 out of 6,400) 93.0% are within the neurodevelopmental pathway.

Key focus areas of concern

- **Clinical Supervision**
- **Crisis Very Urgent Referrals seen within 4 hours**
- **% waiting < 4 weeks to Receive Help – All CYPS**
- **Live within our means**
- **Prone Restraints/Assaults on Patients/Self Harm –** See next page headline for detailed summary

Positive Assurance / Improvement

- **Do you feel safe? -** remains above target for the 4th consecutive month.
- **Clinical Priority Training Courses -** 7 of the 9 courses are meeting the Quarter 2 trajectory within July, two months before quarter end, all 9 courses are showing improvement.
- **Older Adult inpatients discharged with LOS >90 days** – 40% target has been achieved in the month.
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.9% remaining above the internal trajectory of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Reported at 90.9% in the month, remains above the internal target of 85% for the 5th consecutive month
- **Long term segregation and prolonged seclusion** – Specialist Care Group reported a reduction in LTS with the successful ending of one case in Secure CBU following LTS Panel.

Mitigations/actions

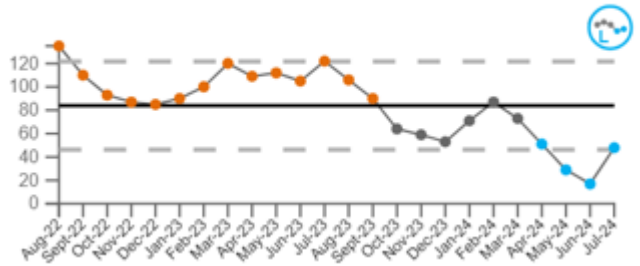
- **Clinical Supervision–** A paper was presented to EMG and BDG outlining the following key areas for performance enhancement: enhancing guidance and supervision quality, improving data accuracy and the ease of recording, and advancing the monitoring, audit, and management of clinical supervision. Current performance at August 27th 2024 is 83.6% compared to 66.4% in July. *Recovery plan in place.*
- **Crisis Very Urgent Referrals seen within 4 hours –** At the July Quality and Performance Committee there was a deep dive into the Crisis service to review the data and the four key improvement areas in progress. These included; 1. Very Urgent and Urgent response times/performance, 2. Crisis Model Review, 3. 136 Optimum Model, and 4. Interface and Trusted assessment *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. A strategic meeting has taken place with ICB leaders and both Trusts across NENC to discuss how as a system we improve access and experience of patients with a neurodevelopmental need. This group agreed to develop immediate recovery plans and a longer-term whole pathway system, approach. The group will meet again to finalise plans in September. *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*

Patient/Staff safety – Headlines and actions summary

Reporting Period: Jul 2024

Prone Restraint

Ref: Q02 Performance: 48 Plan: n/a



Analysis

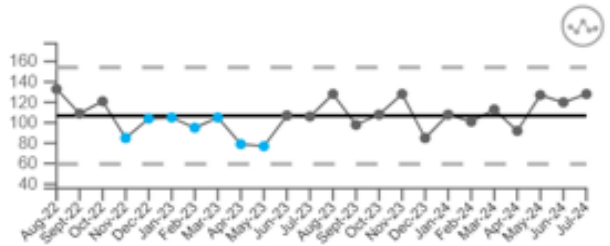
There were 48 Prone restraints reported in July 2024, an increase from 17 in June 2024. This is due to an increase in incidents of two patients on two separate wards (Mitford 1&2 and Riding) who accounted for 30 of the 48 incidents. These two patients accounted for only 3 of the 17 incidents of prone restraint in June 2024.

Improvement actions

- On-going monitoring use of safety pods within clinical areas.
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- PAUSE (Talk 1st initiative) training undertaken in CYPS services both at Ferndene and Lotus in July and August.
- Prone restraints receive regular review in key management and governance groups, which have been further strengthened.
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- Additional PMVA workshops hosted locally to support in reducing use of restrictive interventions.
- Increased emphasis on safer alternatives maintained across Positive and Safe Team and PMVA tutors.

Assaults on Patients

Ref: Q04 Performance: 128 Plan: n/a



Analysis

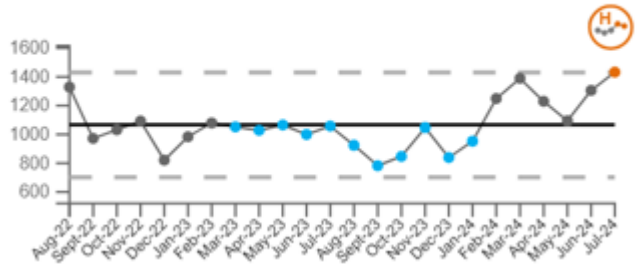
There were 128 assaults on patients in July 2024 which is within expected variation.
Of the 128 assaults in July 2024, 50% of the assaults involved no physical harm and 49% resulted in low physical harm with 1% (1 incident) classified as moderate physical harm. Between May and July 2024 Ruskin and Longview have the had the highest rates of incidents.

Improvement actions

- One of the PSIRF priorities for the year is prevention and management of violence and aggression.
- The Trust has created a dedicated group for violence reduction. Focussing on improved staff health and wellbeing, improved risk management of violence and aggression and regular review of care plans and consideration of other environmental factors and care delivery approaches take place by the MDT.
- Embedding the debrief process including staff and patients to improve psychological safety.

Incidents of self-harm

Ref: Q07 Performance: 1,433 Plan: n/a



Analysis

In July there have been 1,433 reported incidents of self-harm, the highest level reported within 24 months and an increase from 1,305 in June 2024. 54% (773) of the incidents were no physical harm, 45% (641) were low physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm. 15% of the incidents are from the same three patients on CYPS wards. Lamesley (Female Acute) and Lotus (CYPS) are the wards with the highest incidents of self-harm.

Improvement actions

- Incidents of Self Harm is a PSRIF priority - a steering group with project management support has been established.
- On inpatient areas after incidents of self harm, debriefs occur which provide an opportunity to discuss the incident with the patient and to update care plans, safety plans and risk assessments.
- Adopt and monitor the quality of biopsychosocial risk assessments with safety planning both on inpatient wards and within the community
- Review of observations
- Individualised care planning / Review of care plans based on formulation is taking place where it is required.

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Jul 2024

	Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Normal Variation	Consistently Off Target	84.5%	90%	CNTW Std	High (Action)	Deteriorated in the month and remains below target	SR
	C02	How was the care we provided?	SPC n/a	SPC n/a	87.9%	90%	CNTW Std	High (Action)	Improved in the month though remains below target	SR
	C03	Did you feel safe?	Normal Variation	Achieve at Random	90.8%	90%	CNTW Std	Low (On Track)	Remains above target for 4th consecutive month	SR
People	P01	Sickness in Month	Normal Variation	Consistently Off Target	6.4%	5%	NHSE Std	High (Action)	Deteriorated in month, excludes NTW Solutions data	LS
	P02	All Staff Priority Training	Normal Variation	Consistently Off Target	70.0%	100%	CNTW Std	High (Action)	7 out of 10 prioritised training courses achieved target in July	LS
	P03	Clinical Staff Priority Training	SPC n/a	SPC n/a	77.8%	100%	CNTW Std	Med (Monitoring)	7 out of 9 prioritised training courses achieved trajectory in July	LS
	P04	Appraisal rate	Normal Variation	Consistently Off Target	76.7%	85%	CNTW Std	High (Action)	Remains off target but improved in the month - excludes NTW Solutions	LS
	P05	% Clinical Supervision completed	Improvement	Consistently Off Target	66.2%	80%	CNTW Std	High (Action)	Current live data is 78.7% @ 28/08/24	LS
Quality Care	Q01	MRE Restraints	Normal Variation	n/a	8	n/a	n/a	Med (Monitoring)	Decreased in the month, 4th consecutive month below average	RN
	Q02	Prone Restraints	Improvement	n/a	48	n/a	n/a	Med (Monitoring)	Increased in the month, significant improvement over 24 months	RN
	Q03	Long term segregation and prolonged seclusion	Normal Variation	n/a	14	n/a	n/a	Med (Monitoring)	Improved in the month, no significant change	SR
	Q04	Assaults on Patients	Normal Variation	n/a	128	n/a	n/a	Med (Monitoring)	Increased in the month	RN
	Q05	Assaults on staff	Normal Variation	n/a	489	n/a	n/a	Med (Monitoring)	Marginal increase in the month	RN
	Q06	% of patients with a Safety Plan	SPC n/a	SPC n/a	80.2%	100%	CNTW Std	Med (Monitoring)	Improved in the month	RN
	Q07	Reducing incidents of self-harm	Concern	n/a	1,433	n/a	n/a	Med (Monitoring)	Significant increase for the 2nd consecutive month	RN
	Q08	Rights at Point of Detention	Normal Variation	Consistently Off Target	93.2%	100%	CNTW Std	High (Action)	Performance improved in the month	RN
	Q09	Record of Capacity/ CTT at point of detention	Improvement	Consistently Off Target	66.4%	100%	CNTW Std	High (Action)	Decreased in the month, remains consistently off target	RN
Person Led Care	A01	Inappropriate Out of Area Placements (OAPs)	Improvement	Achieve at Random	2	3	NHSE LTP	Low (On Track)	2 Out of Area Placements reported active at the end of July	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Normal Variation	Consistently Off Target	92.9%	85%	NHSE Std	High (Action)	Improved in the month, reported below average	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	Achieve at Random	22.8%	20%	CNTW Std	Med (Monitoring)	Improved in the month but off target	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	40.0%	40%	CNTW Std	Low (On Track)	Improved in the month reported at target	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Consistently Off Target	11.9%	7.5%	NHSE Std	High (Action)	Remains off track and has deteriorated in the month	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Concern	Achieve at Random	29.3%	60%	CNTW Traj	High (Action)	53 out of 181, less than a 3rd very urgent referrals seen within 4 hours	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Normal Variation	Achieve at Random	82.8%	85%	CNTW Std	Med (Monitoring)	322 out of 389, deteriorated in the month and below target	RD
	A08	% PLT ED Referrals seen within 1 hour	Improvement	Consistently Off Target	80.9%	80%	CNTW Std	Med (Monitoring)	On target for the last 4 months, improved last 12 months	RD
	A09	% PLT Ward Referrals seen within 24 hours	Improvement	Achieve at Random	90.9%	85%	CNTW Std	Low (On Track)	Reported above the internal target for the 5th consecutive month	RD
	A10	% Waiting 4 wks or less to treatment (WAAOP)	Normal Variation	Consistently Off Target	34.4%	45%	CNTW Traj	High (Action)	65.6% (1,520 of 2,316) have been waiting longer than 4 weeks	RD
	A11	% Waiting 4 wks or less to receive help (CYPS)	Concern	Consistently Off Target	8.4%	25%	CNTW Traj	High (Action)	91.6% (5,860 of 6,400) have been waiting longer than 4 weeks	RD
	A12	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	87.9%	53%	CNTW Std	Low (On Track)		RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC n/a	n/a	-£6.3m	-£8.4m	n/a	High (Action)	The Trust delivered a £6.3m deficit in line with the financial plan	KS
	S02	Income & Expenditure Forecast	SPC n/a	n/a	-£3.2m	-£3.1m	n/a	Low (No Target)	The Trust is planning to deliver against the requirements for the year	KS
	S03	All staff WTEs	SPC n/a	n/a	8,615	n/a	No Target	Low (No Target)	WTE numbers have decreased by 65 wte since last month	KS
	S04	Capital spend compared to plan (£)	SPC n/a	n/a	£1.0m	£1.4m	n/a	Low (No Target)	Plan to deliver the approved capital programme, £2.4m over the CDEL	KS
	S05	Cash balance compared to plan (£)	SPC n/a	n/a	£37.2m	£23.4m	n/a	Low (On Track)	The Trust cash balances are higher than plan at month 4	KS

Commitments to our Carers & Patients - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

- **How was your experience? (FFT) –** Performance was reported at 84.5% for July, this was a slight decrease on June 24 (85.7%). The 90% target has not been met. The latest national published Mental Health Services FFT score for England is reported at 85.0% (April 24) compared to the CNTW position of 81.2% (April 24).

Selected Your Voice questions

- **How was the care we provided?** – 87.9% of people said care was Good or Very Good, an increase on June (86.4%). Although not reaching the 90% target we will be able to identify the areas of poor experience in the coming months and mitigate.
- **Did you feel safe? –** 511 people responded to this question, of which, 47 reported not feeling safe, in comparison to 425 feeling safe. 8 of the people not feeling safe reported this in relation to the 111 service. A total of 39 people either didn't know or did not answer the question.

Key focus areas of concern

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

Positive Assurance / Improvement

- **Did you feel safe? –** remains the best performing question with 90.8% of people feeling safe, the 4th consecutive month reported above the 90% target

Mitigations/actions

How was your experience? (FFT)

- 56 of 534 respondents said their experience of our services was poor or very poor.
- Inpatient services have the highest satisfaction rating of 89.5%, Specialist services reported 87.8% and Community services reported the lowest score of 81.8% during July.

How was the care we provided?

- 519 people responded to this question, with 456 (88.2%) reporting a good (100) or very good (356) experience of the care provided.
- 45 people (8.7%) of respondents reported a poor (14) or very poor (31) experience.

Awareness sessions are being delivered for staff to help them understand the new dashboard and the feedback options for service users and carers. Sessions at Hopewood Park have been well attended by a range of roles and inpatient settings.

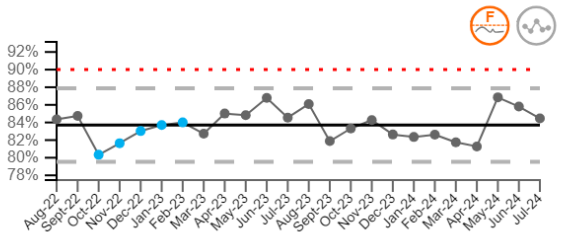
Feedback and You Said – We Did posters are discussed on all local/CBU agendas, most commonly through Quality Standards meetings, with good practice and areas for improvement being discussed.,

Commitments to our Carers & Patients

How was your experience? (FFT)

High (Action)

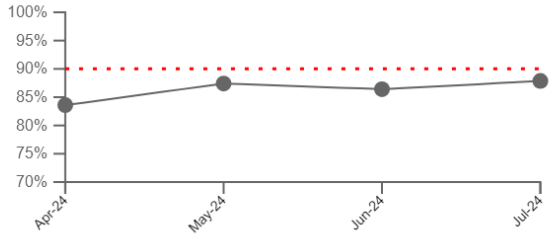
Ref: C01 Performance: 84.5% CNTW Std: 90%



How was the care we provided?

High (Action)

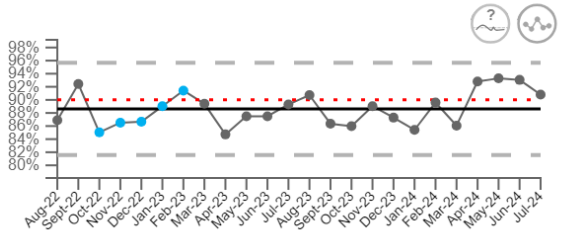
Ref: C02 Performance: 87.9% CNTW Std: 90%



Did you feel safe?

Low (On Track)

Ref: C03 Performance: 90.8% CNTW Std: 90%



Great Place to Work - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

Sickness Absence

- The confirmed sickness for June 2024 is reported at 6.4% (excluding NTW Solutions).
- The sickness metrics runs one month behind to allow time for ESR to be updated from Allocate on the 10th of every month.
- The provisional sickness for July 2024 is reported at 6.39% remaining above the 5% standard.

% of Training Compliance (Courses with a standard)

- In July 2024, Priority Training for All Staff is reported at 70.0%. Currently 7 out of the 10 identified priority training requirements are achieving target. Information Governance, Corporate Induction and Local induction remain below target.

Clinical Supervision

- Performance has improved and is reported at 66.2% compared to July 24 when reported at 59.3%, remaining below Trust 80% standard although current performance as at 28/08/24 excluding exemptions 78.7%

Appraisals

- Performance has increased and is reported at 76.7% compared to June 24 when reported at 75.1%, remaining below Trust 80% standard.

Key focus areas of concern

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

Positive Assurance / Improvement

- **Clinical Priority Training Courses -** 7 of the 9 courses are meeting the Quarter 2 trajectory within July, two months before quarter end, all 9 courses are showing improvement.

- **All Staff Priority Training**
  - **Local Induction** – improvement in performance from 84.9% to 86.8% in July, following focussed work related to updating records.

Mitigations/actions

Sickness Absence

- Sickness Clinics/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 Care Groups when staff trigger points. Ensuring wellbeing conversations take place, reasonable adjustments considered and referrals support (e.g. Staff Psychological Centre, Optima – occupational Health)
- The Trusts Health and Wellbeing offer continues to be promoted through the Thrive website.

% of Training Compliance (Courses with a standard)

- Monitored within weekly Group Safety meetings and Operational Management Groups (OMG).
- Trajectories established in line with Trust priorities.

Clinical Supervision

- The Director of Allied Health Professionals and Psychological Services will continue to work with Group Nurse Directors to establish methods to improve awareness and understanding of clinical supervision.
- Pilot to be launched recording Clinical Supervision with ESR within Bridgewell and Newcastle and Gateshead Community CBU.

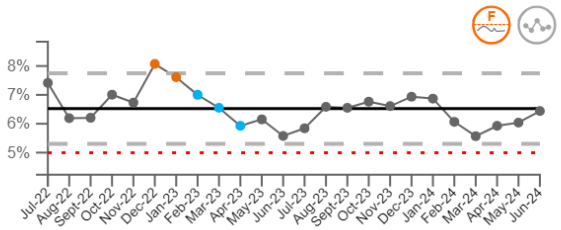
Great Place to Work

Reporting Period: Jul 2024

Sickness in Month

High (Action)

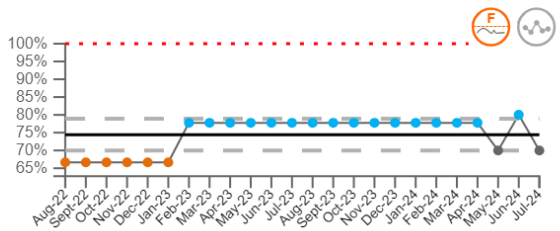
Ref: P01 Performance: 6.4% NHSE Std: 5%



All Staff Priority Training

High (Action)

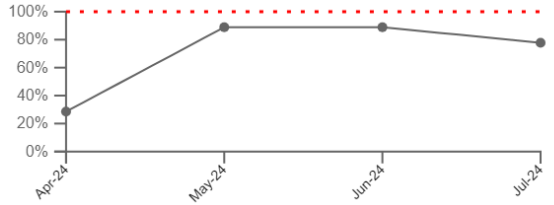
Ref: P02 Performance: 70.0% CNTW Std: 100%



Clinical Staff Priority Training

Med (Monitoring)

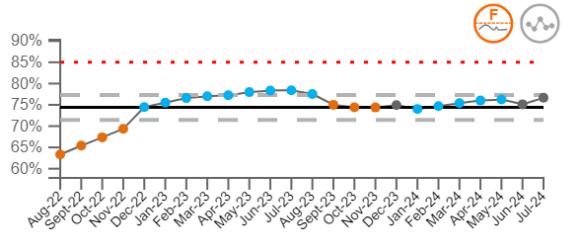
Ref: P03 Performance: 77.8% CNTW Std: 100%



Appraisal rate

High (Action)

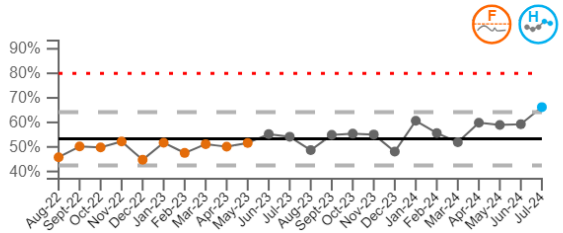
Ref: P04 Performance: 76.7% CNTW Std: 85%



% Clinical Supervision completed

High (Action)

Ref: P05 Performance: 66.2% CNTW Std: 80%



Quality Care, Everyday - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

- **% of Patients with a Risk Management and Personalised Safety Plan -** Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards. Community metric methodology is going through review.
- **Record of Capacity/Consent to Treatment (CTT) at point of detention - rights at Point of Detention** – is consistently off target, in July performance decreased and remains 33.6% below target.
- **Prone Restraints** – There have been significant reductions from levels at 100 a month 12 months ago. However, there has been an uptick from 17 in June to 48 in July due to 2 patients on two wards accounting for 30 of the 48 incidents.
- **Assaults on Patients** – Increased in the month, highest level reported for 24 months. 54% involved no physical harm and 46% was due to low physical harm. There were no higher levels of harm.
- **Reducing Incidents of self-harm –** 54% (773) of the incidents were no physical harm, 45% (641) were low physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm.
- **Long term segregation and prolonged seclusion** – Decreased in the month and remains reported below average. Several patients require specialised placements therefore system blocks are a significant factor in the use of LTS

Key focus areas of concern

- **Prone Restraints**
- **Staff and Patient Assaults**
- **Reducing Incidents of self-harm**

Positive Assurance / Improvement

- **MRE Restraint** – Decreased in the month, remains reported below average.
- **Prone Restraint –** despite a recent uptick in July the overall trend of use of prone restraint has reduced over the last two years.

Mitigations/actions

- **Prone restraints -** Strengthening governance and overall ambition for prone restraint as part of RRI commenced. On-going monitoring use of safety pods within clinical areas. Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention. PAUSE (Talk 1st initiative) training undertaken in CYPS services both at Ferndene and Lotus in July and August. Additional PMVA workshops hosted locally to support in reducing use of restrictive interventions..
- **Staff and Patient Assaults –** One of the PSIRF priorities for the year is prevention and management of violence and aggression. The Trust has created a dedicated group for violence reduction. Focussing on improved staff health and wellbeing, improved risk management of violence and aggression and regular review of care plans and consideration of other environmental factors and care delivery approaches take place by the MDT. Embedding the debrief process including staff and patients to improve psychological safety.
- **Incidents of self-harm -** Following these incidents debriefs occur which can be used to share learning across the inpatient care group. Review of patient care plans based on formulation is taking place where it is required. Monitoring of the quality of biopsychosocial risk assessments with safety planning both on inpatient wards and within the community.

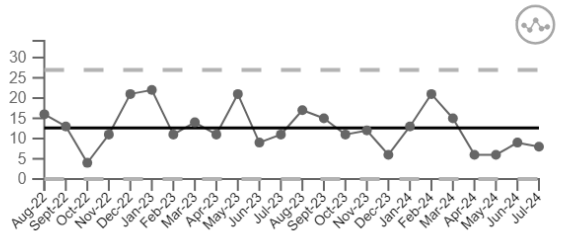
Quality Care, Everyday

Reporting Period: Jul 2024

MRE Restraints

Med (Monitoring)

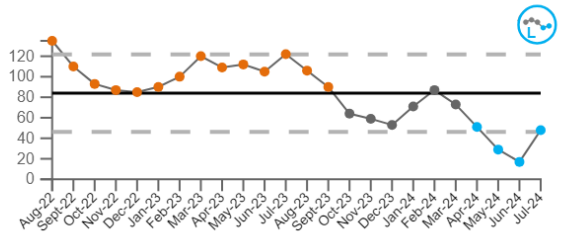
Ref: Q01 Performance: 8 Plan: n/a



Prone Restraints

Med (Monitoring)

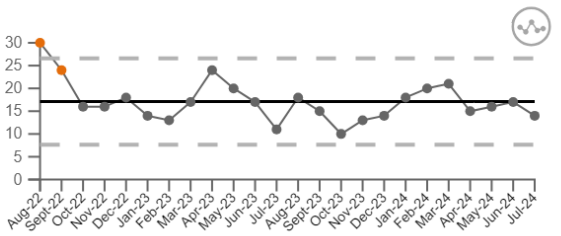
Ref: Q02 Performance: 48 Plan: n/a



Long term segregation and prolonged seclusion

Med (Monitoring)

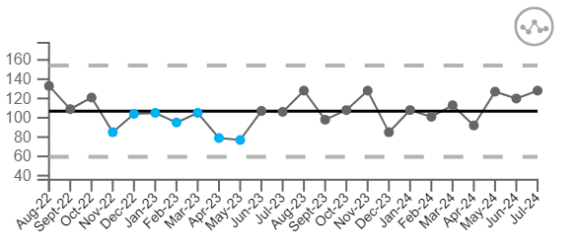
Ref: Q03 Performance: 14 Plan: n/a



Assaults on Patients

Med (Monitoring)

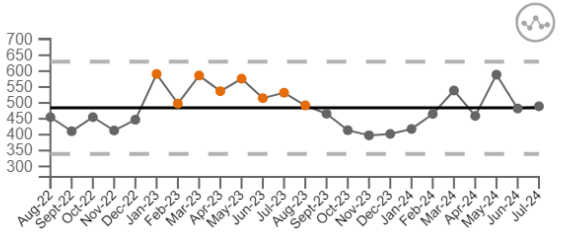
Ref: Q04 Performance: 128 Plan: n/a



Assaults on staff

Med (Monitoring)

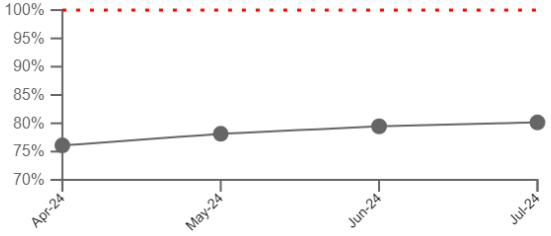
Ref: Q05 Performance: 489 Plan: n/a



% of patients with a Safety Plan

Med (Monitoring)

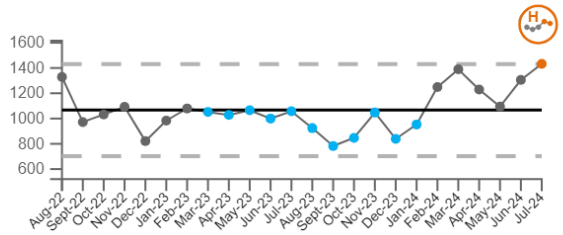
Ref: Q06 Performance: 80.2% CNTW Std: 100%



Reducing incidents of self-harm

Med (Monitoring)

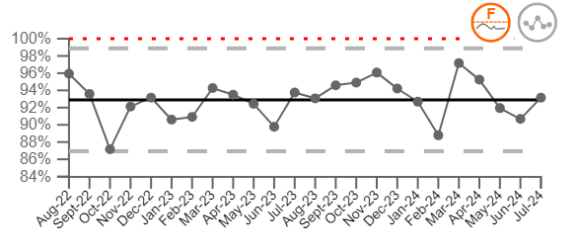
Ref: Q07 Performance: 1,433 Plan: n/a



Rights at Point of Detention

High (Action)

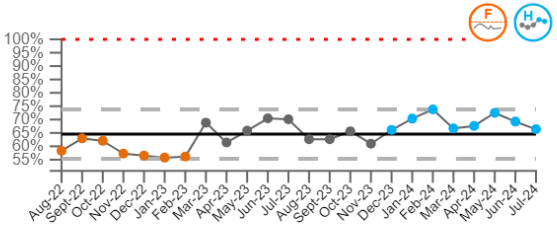
Ref: Q08 Performance: 93.2% CNTW Std: 100%



Record of Capacity/ CTT at point of detention

High (Action)

Ref: Q09 Performance: 66.4% CNTW Std: 100%



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

Reporting Period: Jul 2024

Headline Challenges

- **Out of Area Placement Bed Days** – 2 inappropriate placements at the end of the month. Although still on target these are the first since December 2023. This is due to current bed pressures within mainly female Adult Acute MH beds and Older Persons.
- **Bed occupancy –** remains consistently off target despite improving over the last two years, however, bed occupancy has decreased in the month.
- **Clinically Ready for Discharge** – remains consistently off target.
- **Adult inpatients discharged with LOS >60 days** – remains off target
- **Crisis Very Urgent Referrals seen within 4 hours –** At 29.3%, it's the lowest reported performance since February 23. Significant deterioration in the month (43.6% in June).
- **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** – 34.4% of referrals have been waiting 4 weeks or less to treatment, performance improved in the month.
  - **% waiting < 4 weeks to Receive Help** – 8.4% of referrals have been waiting 4 weeks or less to receive help. Overall, a total of (5,953 out of 6,400) 93.0% waiters 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

- **Older Adult inpatients discharged with LOS >90 days** – 40% target has been achieved in the month.
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.9% performance remains above the internal trajectory of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Reported at 90.9% in the month, remains above the internal trajectory of 85% for the 6th consecutive month

Mitigations/actions

- **Crisis Very Urgent Referrals seen within 4 hours –** At the July Quality and Performance Committee there was a deep dive into the Crisis service to review the data and the four key improvement areas in progress. These included; 1. Very Urgent and Urgent response times/performance, 2. Crisis Model Review, 3. 136 Optimum Model, and 4. Interface and Trusted assessment *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. A strategic meeting has taken place with ICB leaders and both Trusts across NENC to discuss how as a system we improve access and experience of patients with a neurodevelopmental need. This group agreed to develop immediate recovery plans and a longer-term whole pathway system, approach. The group will meet again to finalise plans in September. *Recovery plan in place*

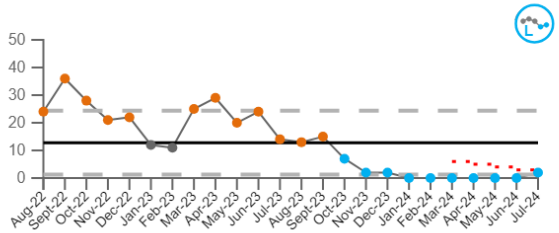
Person Led Care, when and where it's needed

Reporting Period: Jul 2024

Inappropriate Out of Area Placements (OAPs)

Low (On Track)

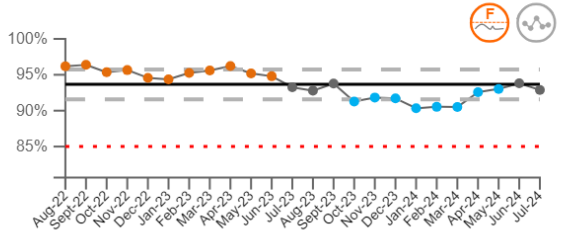
Ref: A01 Performance: 2 NHSE LTP: 3



Bed Occupancy including leave (open beds on RiO)

High (Action)

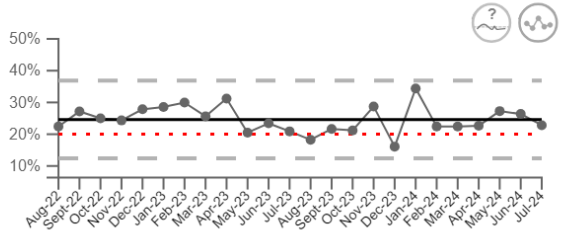
Ref: A02 Performance: 92.9% NHSE Std: 85%



% Adult inpatients discharged with LOS > 60 days

Med (Monitoring)

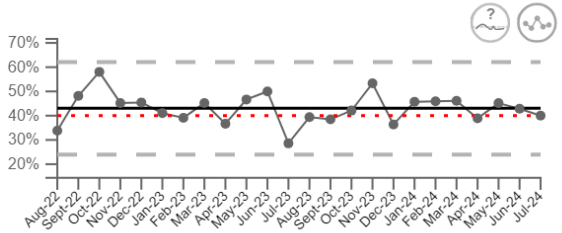
Ref: A03 Performance: 22.8% CNTW Std: 20%



% OP inpatients discharged with LOS > 90 days

Low (On Track)

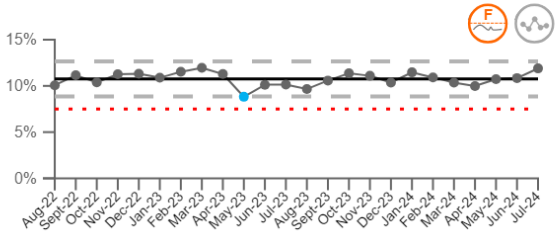
Ref: A04 Performance: 40.0% CNTW Std: 40%



Clinically Ready for Discharge (formerly DTOC)

High (Action)

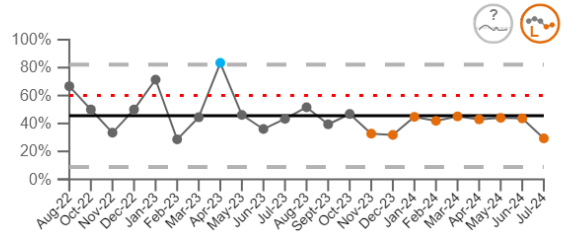
Ref: A05 Performance: 11.9% NHSE Std: 7.5%



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

High (Action)

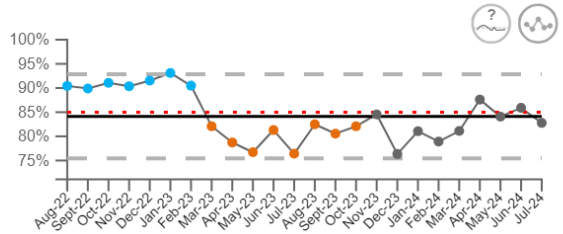
Ref: A06 Performance: 29.3% CNTW Traj: 60%



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

Med (Monitoring)

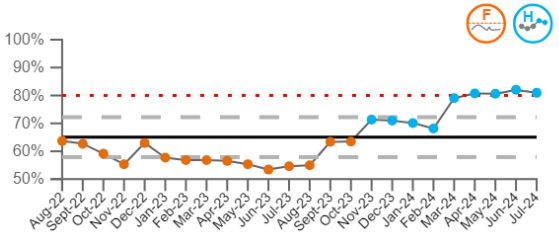
Ref: A07 Performance: 82.8% CNTW Std: 85%



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

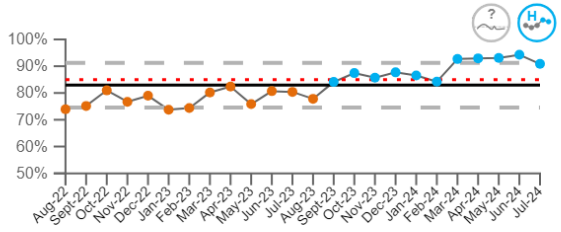
Ref: A08 Performance: 80.9% CNTW Std: 80%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

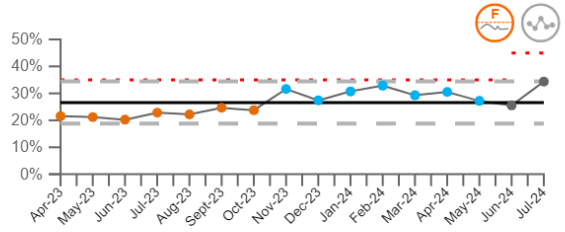
Ref: A09 Performance: 90.9% CNTW Std: 85%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

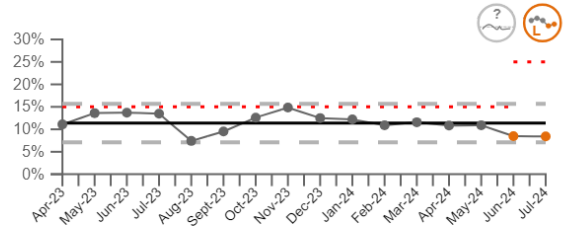
Ref: A10 Performance: 34.4% CNTW Traj: 45%



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

High (Action)

Ref: A11 Performance: 8.4% CNTW Traj: 25%



Sustainable for the Long Term - Headline Commentary

Headline Challenges

- Up to month 4 the Trust is generating £6.2m deficit. This reflects delivering a £0.3m financial surplus in July. The in month surplus has been generated from the ongoing review the balance sheet. The one-off benefit comes from the reduction of some specific pension balances which are no longer a liability. There is no cash benefit from the reduction of these balances sheet totals.
- The £6.2m deficit £2.1m ahead of the Trust plan at month 4 for a £8.4m deficit. The Trust 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 4 the Trust has spent £3.5m on agency staff against a plan £3.6m.
- 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 £30.2m at the end of Month 4 which is higher than the plan at month 4, but 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.
- Trust cash balances are reducing month on month.

Positive Assurance / Improvement

- The Trust is reporting a reduction of 150 wte from April to July. The reduction is mainly across Substantive staff (72wte and bank 86 wte).
- The Trust has seen as reduction in wte from June to Jul of 65 WTE (35wte in substantive and 30 in agency).
- 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 / worsen the financial forecast. A upside and downside scenario is being prepared.
- 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.

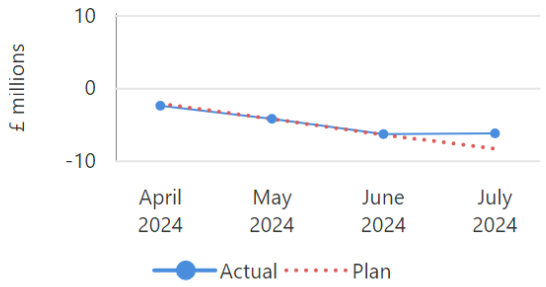
Sustainable for the Long Term

Reporting Period: Jul 2024

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

High (Action)

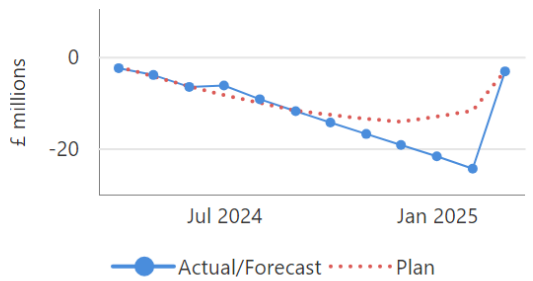
Ref: S01 **Performance: -£6.3m** **Plan: -£8.4m**



Income & Expenditure Forecast

Low (No Target)

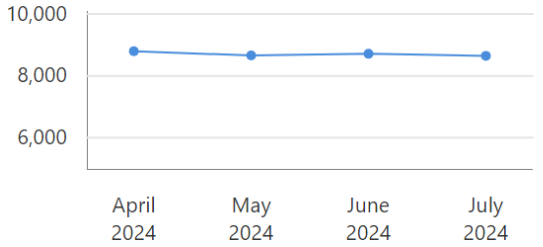
Ref: S02 **Performance: -£3.2m** **Plan: -£3.1m**



All staff WTEs

Low (No Target)

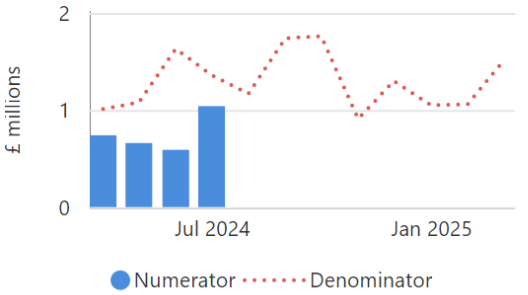
Ref: S03 **Performance: 8,615** **No Target: n/a**



Capital spend compared to plan (£)

Low (No Target)

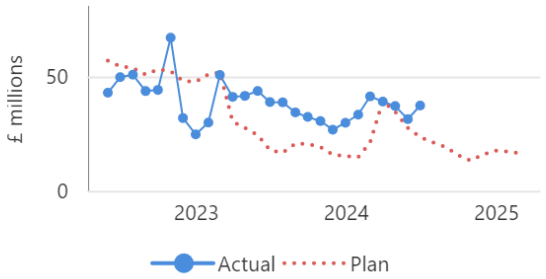
Ref: S04 **Performance: £1.0m** **Plan: £1.4m**



Cash balance compared to plan (£)

Low (On Track)

Ref: S05 **Performance: £37.2m** **Plan: £23.4m**



C01 How was your experience? (FFT)

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

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

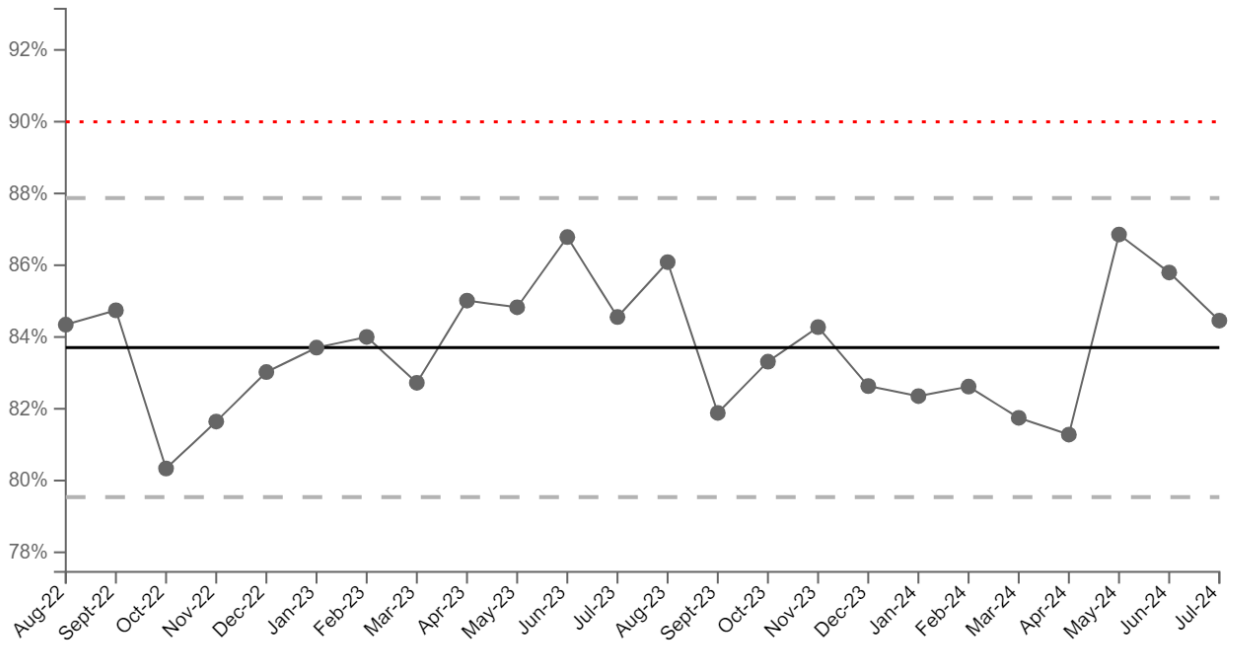
84.5%

tgt. 90%
n. 451
d. 534

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	81.8%	261	319	90%	SPC n/a	SPC n/a
Inpatient Care Group	89.5%	51	57	90%	SPC n/a	SPC n/a
Specialist Care Group	87.8%	137	156	90%	SPC n/a	SPC n/a
Support & Corporate	100.0%	2	2	90%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Performance was reported at 84.5% for July, which is a decrease from June (86.4%) remaining below the 90% target.

Root Cause of the performance issue

- Most negative experiences are reported in Initial Response Northumberland (4 very poor, 1 poor) and the 111 service (3 very poor, 5 poor).

Improvement Actions

- Staff are being supported to explore service user and carer experience relating to their service(s) through the Your Voice dashboard.
- The Care Group leadership teams are supported with information on which of their teams have created You Said – We Did posters, including a mid-month position. Supporting groups to be responsive to feedback in a meaningful way.

Expected impact and by when

The survey is beginning to embed, with over 500 service users and carers sharing their experience, in May (570), June (521) and July (550). This offers the Trust good feedback to respond to when looking to shape services to suit the needs of people accessing them.

If feedback levels remain consistently high, there will be opportunities to be responsive to emerging themes at team/CBU/Group and Trust level.

C02 How was the care we provided?

How was the care we provided?

Risk Rating: **High (Action)**

tgt. = target n. = numerator d. = denominator

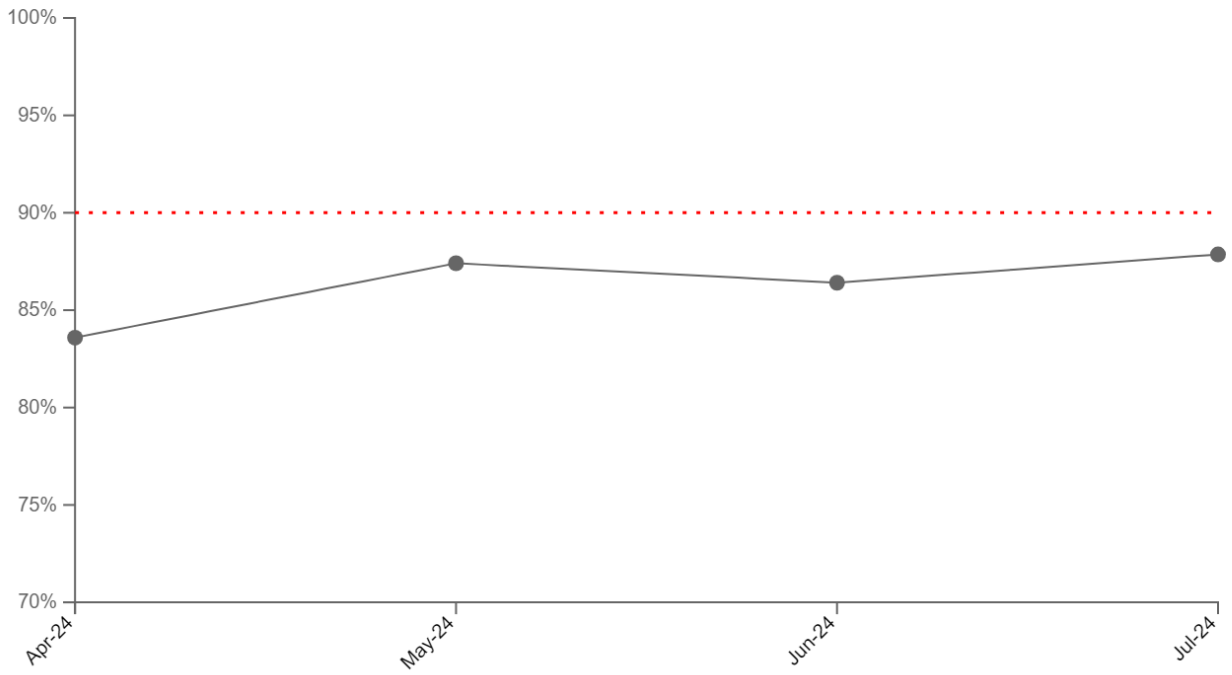
87.9%	tgt.	90%
	n.	456
	d.	519

SPC n/a

SPC n/a

DQ - No Concern

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



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	85.4%	264	309	90%	SPC n/a	SPC n/a
Inpatient Care Group	91.1%	51	56	90%	SPC n/a	SPC n/a
Specialist Care Group	91.5%	139	152	90%	SPC n/a	SPC n/a
Support & Corporate	100.0%	2	2	90%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Performance was reported at 87.9% for July, which is an increase from June (86.4%), remaining slightly below the 90% target.

Root Cause of the performance issue

- 519 people responded to this question, with 456 reporting a good experience of the care provided.
- 45 people of respondents reported a poor experience (31 very poor and 14 poor).

Improvement Actions

- The 111 service had the most very poor experiences (5). It is an opportunity to explore this as a team and identify improvement options.
- The new dashboard is available to staff and support is being offered to help staff explore the data and respond to themes as they emerge.
- Inpatient services had the lowest feedback levels for this question during July with 56 responses, 11 of these were from carers. Ensuring the carer voice is heard requires focus within relevant care groups.

Expected impact and by when

The survey is offering good levels of experience data, offering all levels of the organisation the opportunity to be responsive and improve experiences.

You Said – We Did posters are a useful way of showing responsiveness.

P01 Sickness in Month

Percentage of in month sickness absence

Risk Rating: High (Action)

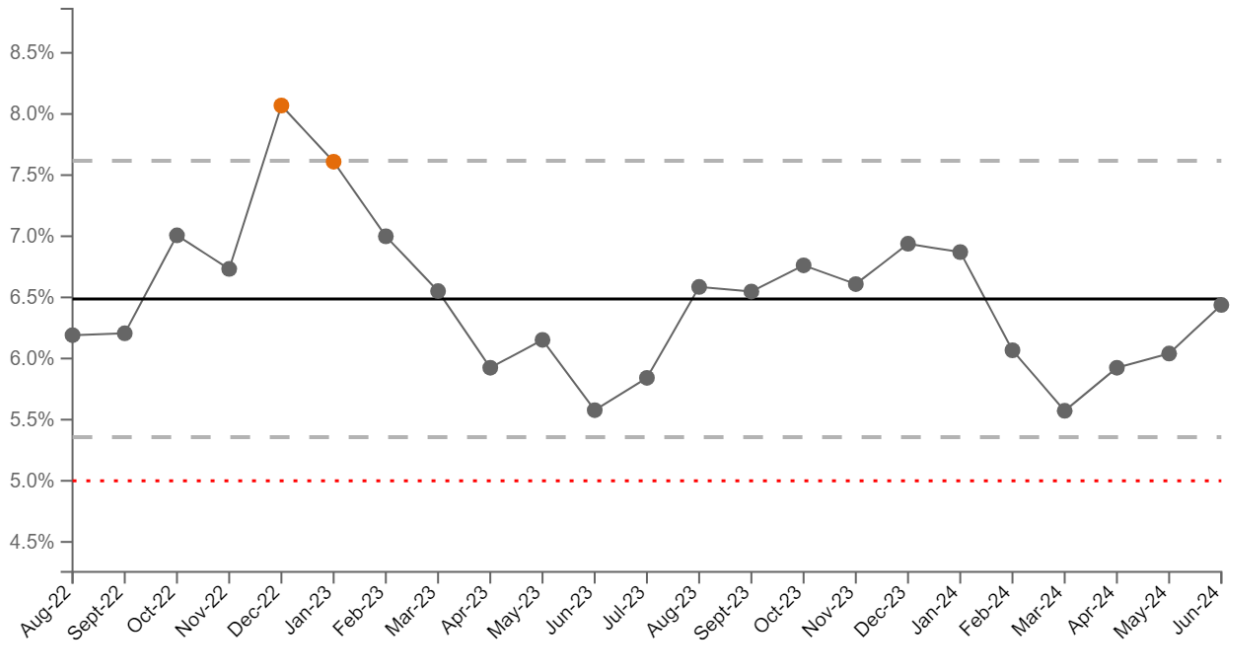
tgt. = target n. = numerator d. = denominator

6.4% tgt. 5% n. 14,234 d. 221,100

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	6.4%	5,834	90,551	5%	Normal Variation	Consistently Off Target
Inpatient Care Group	7.5%	3,722	49,939	5%	Normal Variation	Consistently Off Target
Other Care Group	0.0%	0	0	5%	Improvement	Achieve at Random
Specialist Care Group	7.2%	3,704	51,309	5%	Normal Variation	Consistently Off Target
Support & Corporate	3.3%	974	29,302	5%	Normal Variation	Consistently Achieve

Feedback

What the chart tells us

The chart shows the confirmed sickness for June 2024 which is reported at 6.4% (excludes NTW Solutions). N.B The sickness in month is reported one month behind to allow ESR to be fully updated from Allocate to accurately reflect the position. 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 cases.

Expected impact and by when

- Predicted absence reduction as previous year trends.

P02 All Staff Priority Training

All Staff Priority Training

Risk Rating: High (Action)

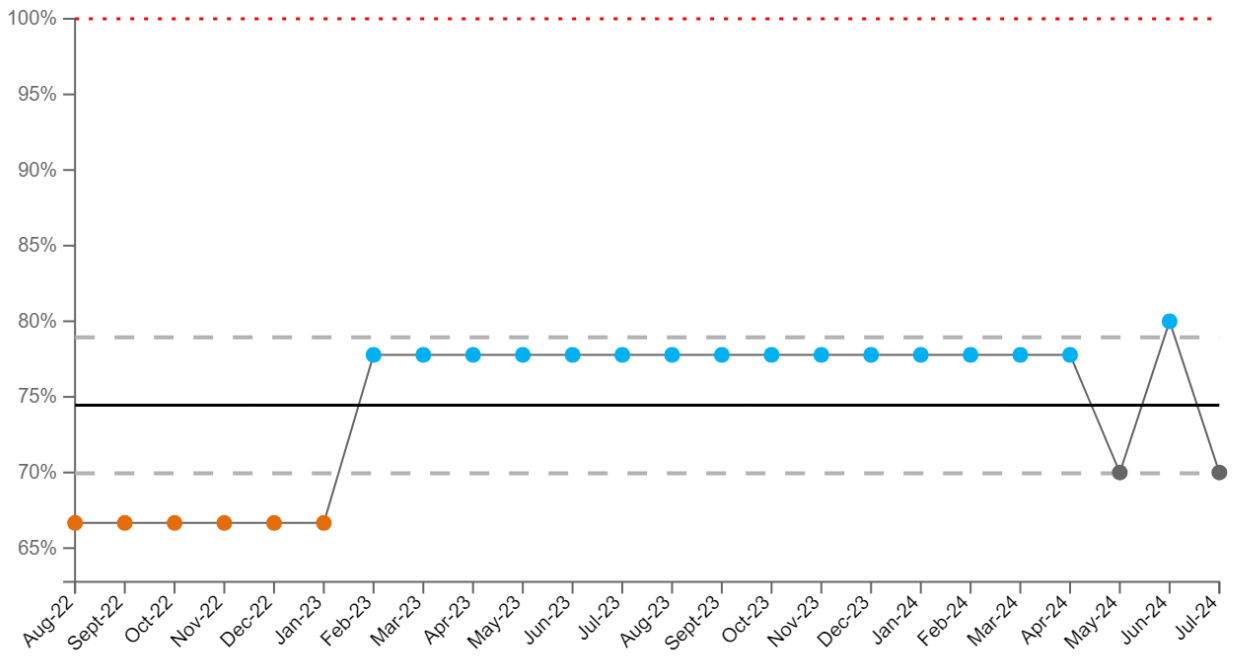
tgt. = target n. = numerator d. = denominator

70.0%	tgt.	100%
	n.	7
	d.	10

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	100.0%	10	10	100%	Improvement	Consistently Off Target
Inpatient Care Group	80.0%	8	10	100%	Improvement	Consistently Off Target
Other Care Group	50.0%	5	10	100%	Normal Variation	Consistently Off Target
Specialist Care Group	80.0%	8	10	100%	Normal Variation	Consistently Off Target
Support & Corporate	60.0%	6	10	100%	Concern	Consistently Off Target

Feedback

What the chart tells us

Training Compliance for all staff is reported at 70% for July 2024. Currently 7 out of the 10 identified priority training requirements are achieving target. Information Governance, Corporate Induction and Local Induction remain below target. Further work is required on the training data as this percentage currently excludes Web Risk Register and PSIRF (Patient Safety Incident Response Framework). 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
- Local Inductions not recorded at time of commencement

Improvement Actions

- Priority training has been agreed within a Training Performance Framework. Includes 53 Corporate and Operational courses with training standards.
- Continue to improve data completeness of needs analysis and who has been trained and not recorded.
- Manage demand and capacity – review offer for all courses and trainers.
- CBU level training trajectory plans established in line with Trust priorities.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.
- Focus on ensuring IG training remains consistently at the 95% standard.

Expected impact and by when

Increase in training compliance in line with set trajectories.

P03 Clinical Staff Priority Training

Clinical Staff Priority Training

Risk Rating: Med (Monitoring)

tgt. = target n. = numerator d. = denominator

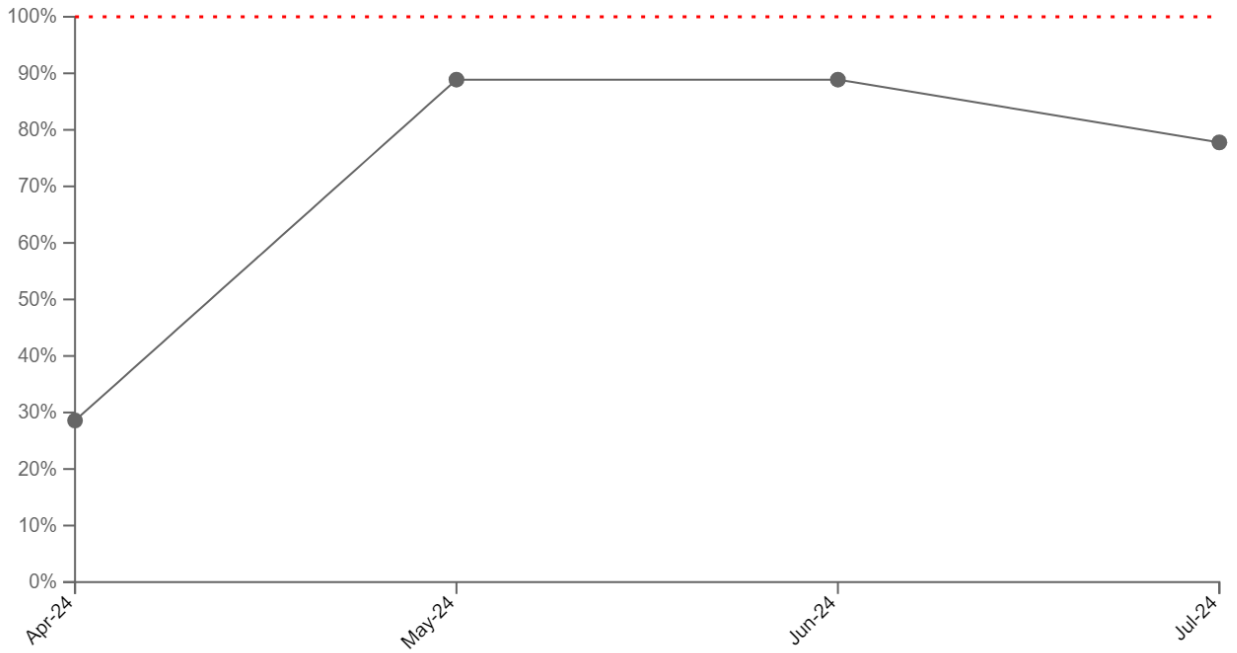
77.8%	tgt.	100%
	n.	7
	d.	9

SPC n/a

SPC n/a

DQ - No Concern

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



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	71.4%	5	7	100%	SPC n/a	SPC n/a
Inpatient Care Group	85.7%	6	7	100%	SPC n/a	SPC n/a
Other Care Group	0.0%	0	6	100%	SPC n/a	SPC n/a
Specialist Care Group	88.9%	8	9	100%	SPC n/a	SPC n/a
Support & Corporate	0.0%	0	5	100%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Priority Training Compliance for clinical staff is reported at 77.8% for July 2024. Currently 7 out of the 9 identified priority training requirements are achieving the agreed trajectories. Clinical Risk and Suicide prevention and Resuscitation L3 Adult Immediate Life Support training remain below the agreed trajectory.

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 completeness of needs analysis relating to who has been trained but not recorded.
- Manage demand and capacity – review offer for all courses and trainers e.g. PMVA to improve compliance.
- Bespoke session planned regarding PMVA within Inpatient Care Group.
- CBU level training trajectory plans established in line with Trust priorities.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.

Expected impact and by when

Increase in training compliance in line with set trajectories.

Great Place to Work - Training

All Staff Priority Training

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TA01	Information Governance	Improvement	Consistently Off Target	93.0%	95%	CNTW Std	8,501	9,142	Med (Monitoring)
TA02	Corporate Induction	SPC n/a	SPC n/a	94.4%	95%	CNTW Std	8,630	9,142	Low (On Track)
TA03	Local Induction (Once)	Improvement	Consistently Off Target	86.8%	90%	CNTW Traj	7,928	9,138	Med (Monitoring)
TA04	Safeguarding Adults Level 1	Improvement	Consistently Achieve	96.1%	85%	CNTW Std	1,624	1,690	Low (On Track)
TA05	Safeguarding Children Level 1	Improvement	Consistently Achieve	95.4%	85%	CNTW Std	1,613	1,690	Low (On Track)
TA06	Fire	Improvement	Achieve at Random	89.1%	85%	CNTW Std	8,146	9,142	Low (On Track)
TA07	Equality & Diversity Introduction	Improvement	Consistently Achieve	95.1%	85%	CNTW Std	8,695	9,142	Low (On Track)
TA08	Health & Safety	Improvement	Consistently Achieve	94.7%	85%	CNTW Std	8,661	9,142	Low (On Track)
TA09	Infection Prevention & Control (IPC)	Improvement	Consistently Achieve	92.8%	85%	CNTW Std	8,484	9,142	Low (On Track)
TA10	Moving & Handling Awareness Training	Improvement	Consistently Achieve	94.1%	85%	CNTW Std	8,599	9,142	Low (On Track)

Clinical Staff Priority Training

Assurance is based on 24 months of data

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TC01	Clinical Risk and Suicide Prevention	Normal Variation	Achieve at Random	77.3%	79%	CNTW Traj	2,402	3,106	Med (Monitoring)
TC02	Biopsychosocial at Risk Assessment & Safety Planning	SPC n/a	SPC n/a	85.5%	62%	CNTW Traj	2,654	3,106	Low (On Track)
TC03	Resuscitation L2 Adult Basic Life Support	Improvement	Consistently Off Target	77.2%	77%	CNTW Traj	1,356	1,757	Med (Monitoring)
TC04	Resuscitation L3 Adult Immediate Life Support	Improvement	Consistently Off Target	70.3%	71%	CNTW Traj	2,534	3,605	Med (Monitoring)
TC05	Resuscitation L3 Paediatric Immed Life Support	Improvement	Consistently Off Target	46.2%	45%	CNTW Traj	18	39	Med (Monitoring)
TC06	Resuscitation L2 Paediatric Basic Life Support	Improvement	Consistently Off Target	73.7%	72%	CNTW Traj	437	593	Med (Monitoring)
TC07	PMVA Basic	Improvement	Consistently Off Target	76.3%	74%	CNTW Traj	2,026	2,654	Med (Monitoring)
TC09	Engagement & Observation (3 years)	Improvement	Consistently Off Target	82.9%	81%	CNTW Traj	2,785	3,360	Med (Monitoring)
TC10	Dysphagia Awareness	Improvement	Consistently Off Target	83.5%	75%	CNTW Traj	2,264	2,713	Med (Monitoring)

NB: PSIRF, Corporate Governance and Risk Management Training to be added when available

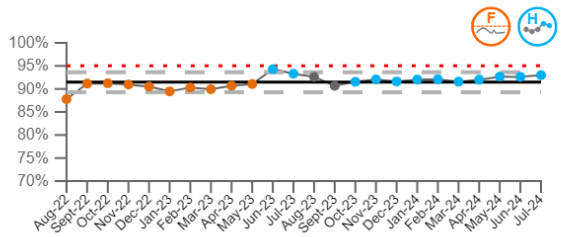
All Staff Priority Training

Reporting Period: Jul 2024

Information Governance

Med (Monitoring)

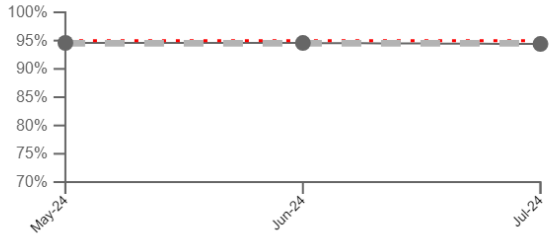
Ref: TA01 Performance: 93.0% CNTW Std: 95%



Corporate Induction

Low (On Track)

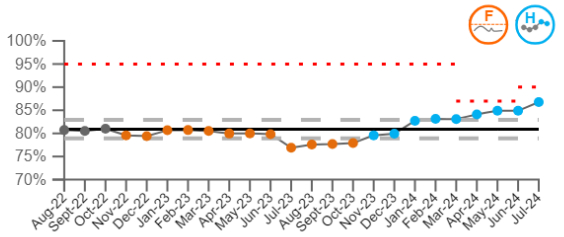
Ref: TA02 Performance: 94.4% CNTW Std: 95%



Local Induction (Once)

Med (Monitoring)

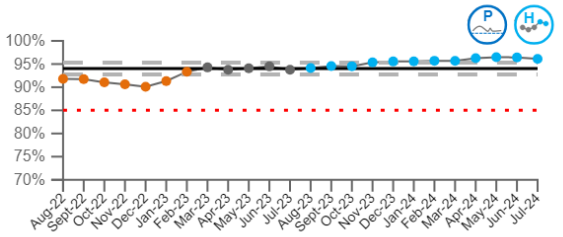
Ref: TA03 Performance: 86.8% CNTW Traj: 90%



Safeguarding Adults Level 1

Low (On Track)

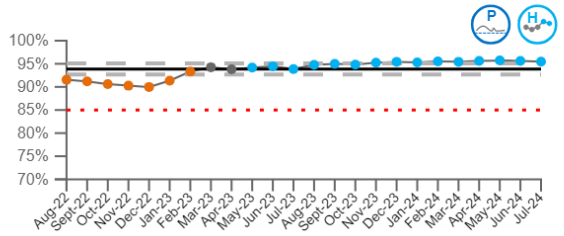
Ref: TA04 Performance: 96.1% CNTW Std: 85%



Safeguarding Children Level 1

Low (On Track)

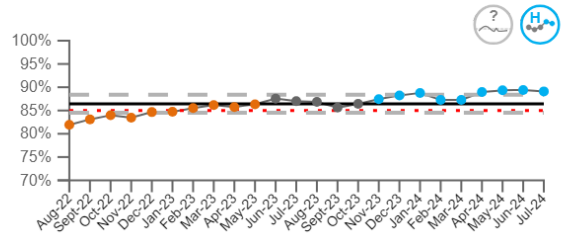
Ref: TA05 Performance: 95.4% CNTW Std: 85%



Fire

Low (On Track)

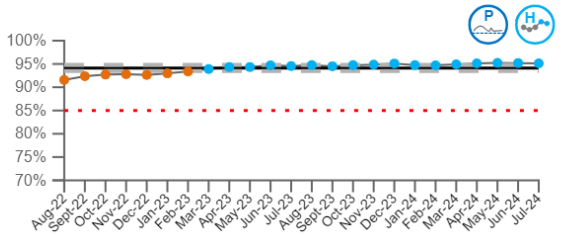
Ref: TA06 Performance: 89.1% CNTW Std: 85%



Equality & Diversity Introduction

Low (On Track)

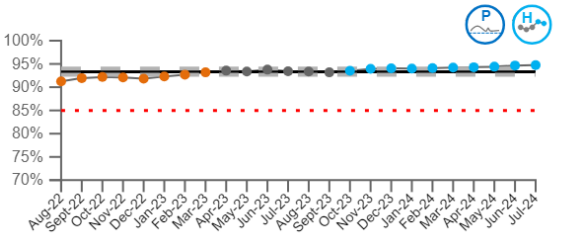
Ref: TA07 Performance: 95.1% CNTW Std: 85%



Health & Safety

Low (On Track)

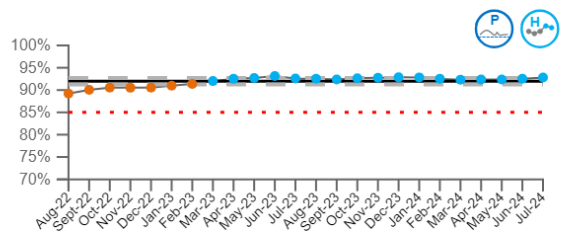
Ref: TA08 Performance: 94.7% CNTW Std: 85%



Infection Prevention & Control (IPC)

Low (On Track)

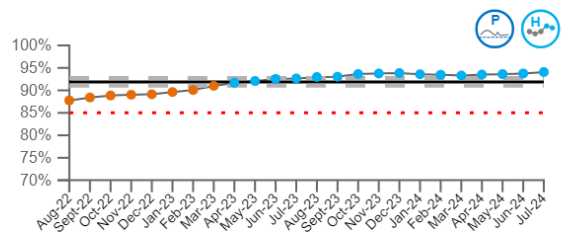
Ref: TA09 Performance: 92.8% CNTW Std: 85%



Moving & Handling Awareness Training

Low (On Track)

Ref: TA10 Performance: 94.1% CNTW Std: 85%



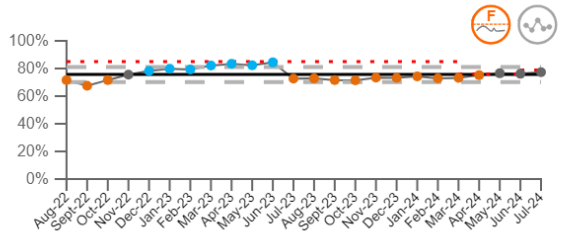
Clinical Staff Priority Training

Reporting Period: Jul 2024

Clinical Risk and Suicide Prevention

Med (Monitoring)

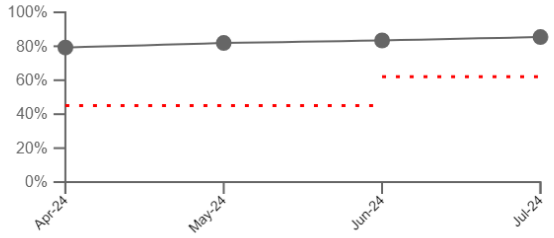
Ref: TC01 Performance: 77.3% CNTW Traj: 79%



Biopsychosocial at Risk Assessment & Safety

Low (On Track)

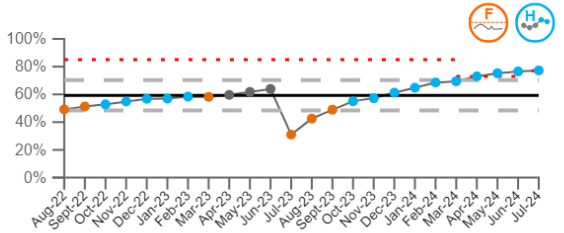
Ref: TC02 Performance: 85.5% CNTW Traj: 62%



Resuscitation L2 Adult Basic Life Support

Med (Monitoring)

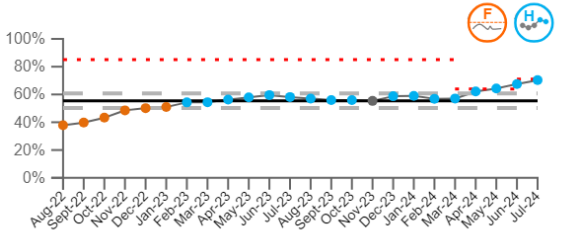
Ref: TC03 Performance: 77.2% CNTW Traj: 77%



Resuscitation L3 Adult Immediate Life Support

Med (Monitoring)

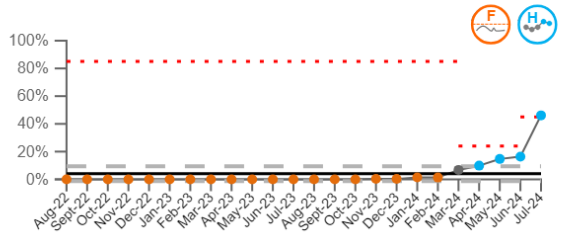
Ref: TC04 Performance: 70.3% CNTW Traj: 71%



Resuscitation L3 Paediatric Immed Life Support

Med (Monitoring)

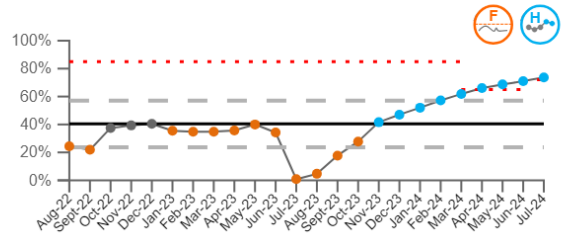
Ref: TC05 Performance: 46.2% CNTW Traj: 45%



Resuscitation L2 Paediatric Basic Life Support

Med (Monitoring)

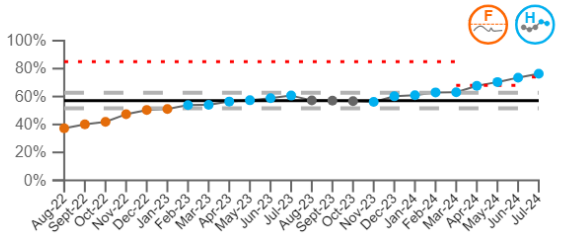
Ref: TC06 Performance: 73.7% CNTW Traj: 72%



PMVA Basic

Med (Monitoring)

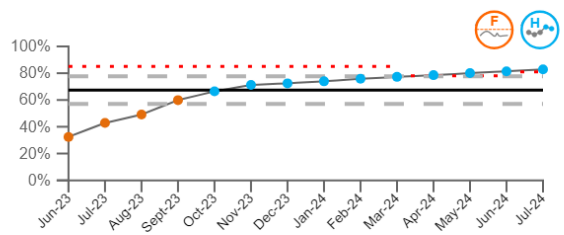
Ref: TC07 Performance: 76.3% CNTW Traj: 74%



Engagement & Observation (3 years)

Med (Monitoring)

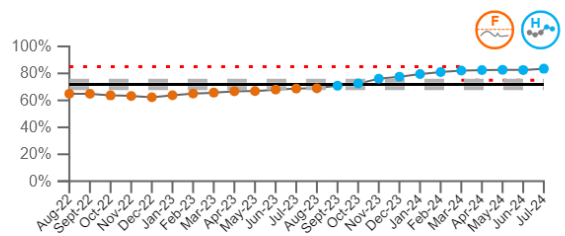
Ref: TC09 Performance: 82.9% CNTW Traj: 81%



Dysphagia Awareness

Med (Monitoring)

Ref: TC10 Performance: 83.5% CNTW Traj: 75%



Please note: From April 2024 the above training is monitored on the agreed trajectories, prior to this date they were monitored on the Trust standard.

P04 Appraisal rate

Appraisal rate

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

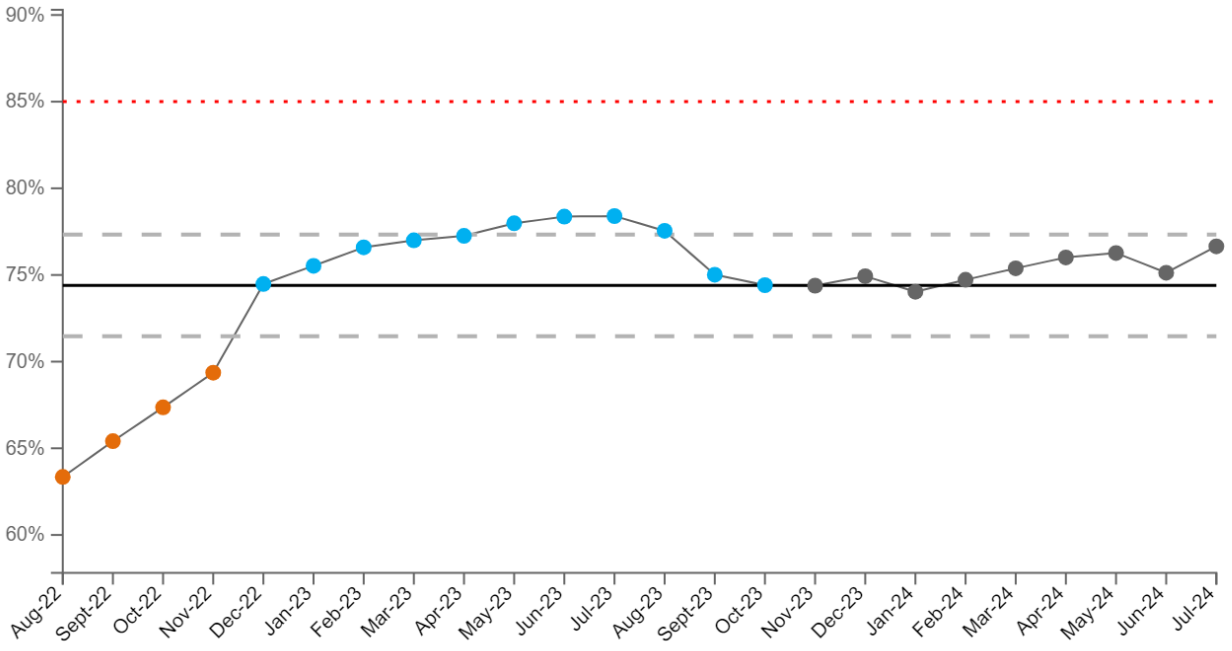
76.7%

tgt. 85%
n. 6,294
d. 8,211

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	81.5%	2,748	3,370	85%	Improvement	Consistently Off Target
Inpatient Care Group	73.6%	1,351	1,836	85%	Normal Variation	Consistently Off Target
Specialist Care Group	76.0%	1,434	1,887	85%	Normal Variation	Consistently Off Target
Support & Corporate	68.1%	761	1,118	85%	Normal Variation	Consistently Off Target

Feedback

What the chart tells us

The reported appraisal rate for July is 76.7% (excluding NTW Solutions), continuing to be reported higher than the mean average, but remaining 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 target of 85%.

P05 % Clinical Supervision completed

Clinical Supervision

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

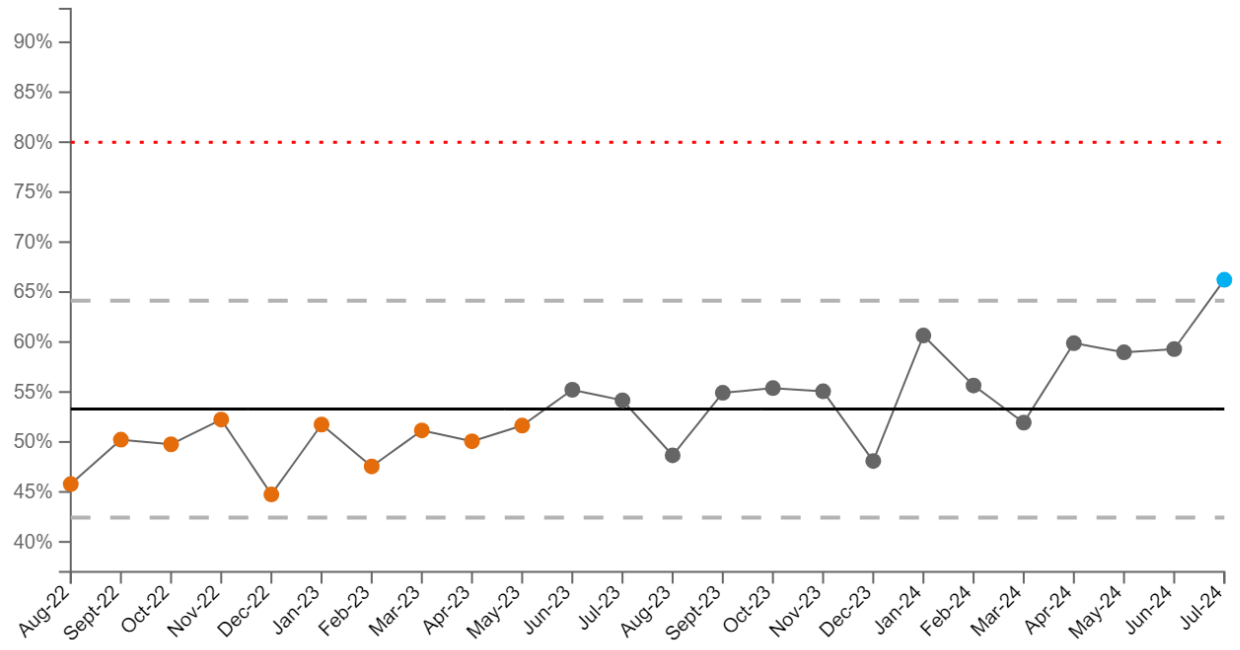
66.2%

tgt. 80%
n. 3,717
d. 5,612

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



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	72.9%	1,655	2,269	80%	Improvement	Consistently Off Target
Inpatient Care Group	59.5%	870	1,463	80%	Normal Variation	Consistently Off Target
Other Care Group	24.9%	45	181	80%	Concern	Consistently Off Target
Specialist Care Group	68.2%	969	1,420	80%	Improvement	Consistently Off Target
Support & Corporate	63.8%	178	279	80%	Improvement	Consistently Off Target

Feedback

What the chart tells us

Performance of 66.2% in July is above the expected range and showing improvement though remains below the 80% standard. Without change the target 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
- Staff delivering supervision may not be linked to staff record or may have more than 1 supervisor providing supervision
- Metric includes staff who are currently exempt or on long term sick leave (Position as at 28/08/24 excluding exemptions 78.7%)

Improvement Actions

- Supervision rate monitored through local Clinical Management Teams, Quality Standards and Oversight meetings within CBU's.
- Setting expectations with CBU leadership team.
- Specific focus and trajectories within Mitford as a hotspot
- Specialist care group have developed trajectories for all CBU's to meet compliance
- Establishing and escalating any recording and data issues.
- Live supervision to be recorded appropriately.
- Mapping required to accurately report who is supervising those staff who require clinical supervision
- Ability to measure the quality of clinical supervision received
- Metric review is underway to understand the differences in reporting across dashboards to ensure consistent reporting.
- Discussion at BDG Workforce on training/awareness for support staff. Director of Allied Health Professionals and Psychological Services to work with Group Nurse Directors to establish methods to improve awareness and understanding of clinical supervision.
- Pilot to be launched recording Clinical Supervision with ESR within Bridgewell and Newcastle and Gateshead Community CBU.

Expected impact and by when

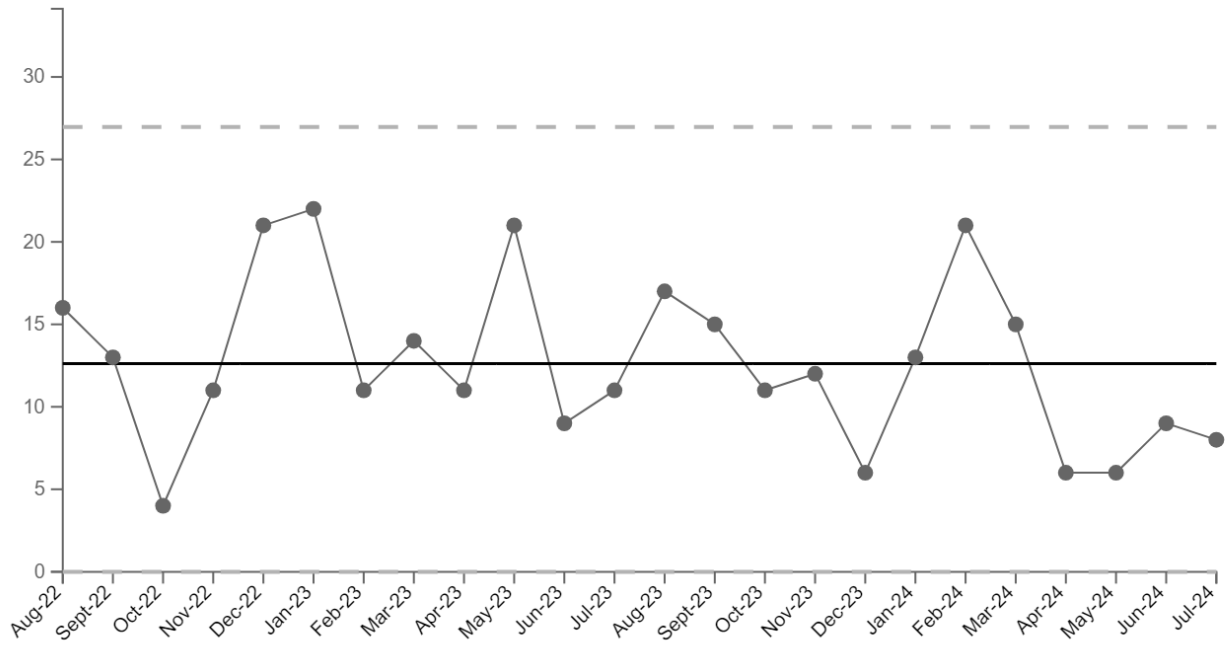
- Commitment from all Care Groups compliance will be achieved by Q3

Q01 MRE Restraints

Number of MRE Restraints

Risk Rating: Med (Monitoring)

8	Not Applicable	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	Target	Variation	Assurance
Community Care Group	0	n/a	Improvement	SPC n/a
Inpatient Care Group	1	n/a	Normal Variation	SPC n/a
Other Care Group	0	n/a	Improvement	SPC n/a
Specialist Care Group	7	n/a	Normal Variation	SPC n/a
Support & Corporate	0	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There were 8 MRE restraints reported in July 2024, relating to 5 patients which is a slight decrease on previous month.

Root Cause of the performance issue

- The necessity for moving complex individuals for external appointments. Some under the direction of the Ministry of Justice
- High levels of perceived/historical risk
- High levels of complexity and acuity within Specialist Care Group, with 3 out of the 4 CBU's having reported usage of MRE in the month of July

Improvement Actions

- Addressed within cohorts and through recent Trauma- informed Care presentations
- Workshops have taken place for CYPS services and Secure Services to develop plans to reduce the use of MRE.
- Robust de-brief process to support learning from incidents and review of care plans.
- Within Mitford Talk 1st initiatives including safewards interventions are used primarily, as well as the Positive Behavioural Support (PBS) model to help support a reduction in situations that may lead to a restrictive intervention.
- Talk 1st training has commenced within induction and is also now within the Healthcare Support Worker Certificate (HCSW) programme
- MRE incidents are being reviewed via the Early Learning Review (ELR)
- Agreed appropriate numbers of staff (within cohorts - day pool, night pool, NSC staff and ward staff on acute wards) to be trained on MRE. This is due to availability of training as well as in line with reducing restrictive practice.

Expected impact and by when

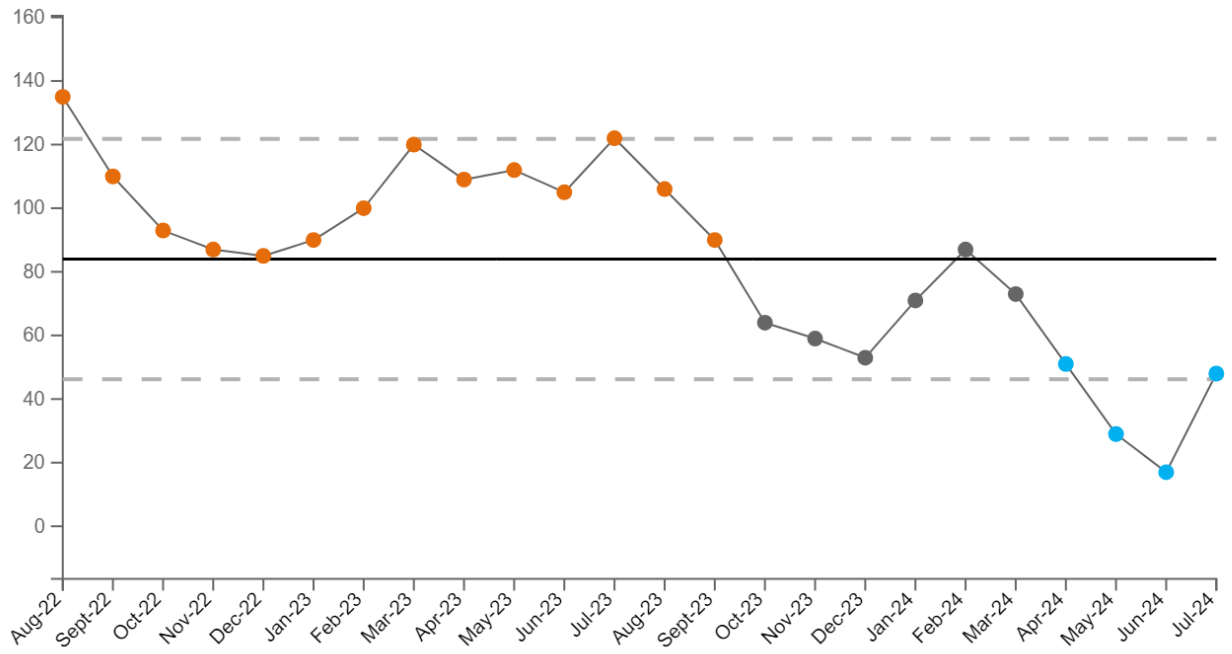
Whilst work ongoing is supporting reduction in use of MRE, reporting is likely to see variance month on month, however usage has reduced overall. Continued reduction throughout 24/25

Q02 Prone Restraints

Number of Prone Restraints

Risk Rating: Med (Monitoring)

48	Not Applicable	Improvement: This indicator is decreasing which shows improvement	DQ - No Concern: There are currently no concerns with the data quality of this indicator



Care Group	Performance	Target	Variation	Assurance
Community Care Group	1	n/a	Normal Variation	SPC n/a
Inpatient Care Group	5	n/a	Improvement	SPC n/a
Other Care Group	0	n/a	Improvement	SPC n/a
Specialist Care Group	42	n/a	Normal Variation	SPC n/a
Support & Corporate	0	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There have been 48 Prone restraints reported in July, an increase from June where 17 prone restraints were reported. There has been a statistically significant reduction in the use of prone restraint.

Root Cause of the performance issue

- Two patients on two wards (Mitford 1&2 and Riding) account for 30 of the 48 incidents.
- Projected yearly figures for Trust-wide prone incidents are currently down by 58% from last year
- The proportion of prone restraint within Inpatient Care has remain largely unchanged following significant reductions, with all in month prone restraint incidents occurring in the urgent care pathway. PICU (Beckfield) has the highest number of prone restraint incidents YTD.
- Specialist Care Group have seen an increase in acuity across all pathways within the Group, particularly within Autism Inpatient and Specialist CYPS. Many of the reported restraints are relating to specific individuals within the wards.
- Talk 1st initiatives including safewards interventions are used primarily, as well as the PBS model to help support a reduction in situations that may lead to a restrictive intervention

Improvement Actions

- On-going monitoring use of safety pods within clinical areas,
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- PAUSE (Talk 1st initiative) training undertaken in CYPS services both at Ferndene and Lotus in July and August
- This area continues to receive regular review in key management and governance groups.
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- Additional PMVA workshops hosted locally supporting reduced use of restrictive interventions.
- Increased emphasis on safer alternatives to prone restraint have been maintained across both the Positive and Safe Team and PMVA tutors.

Expected impact and by when

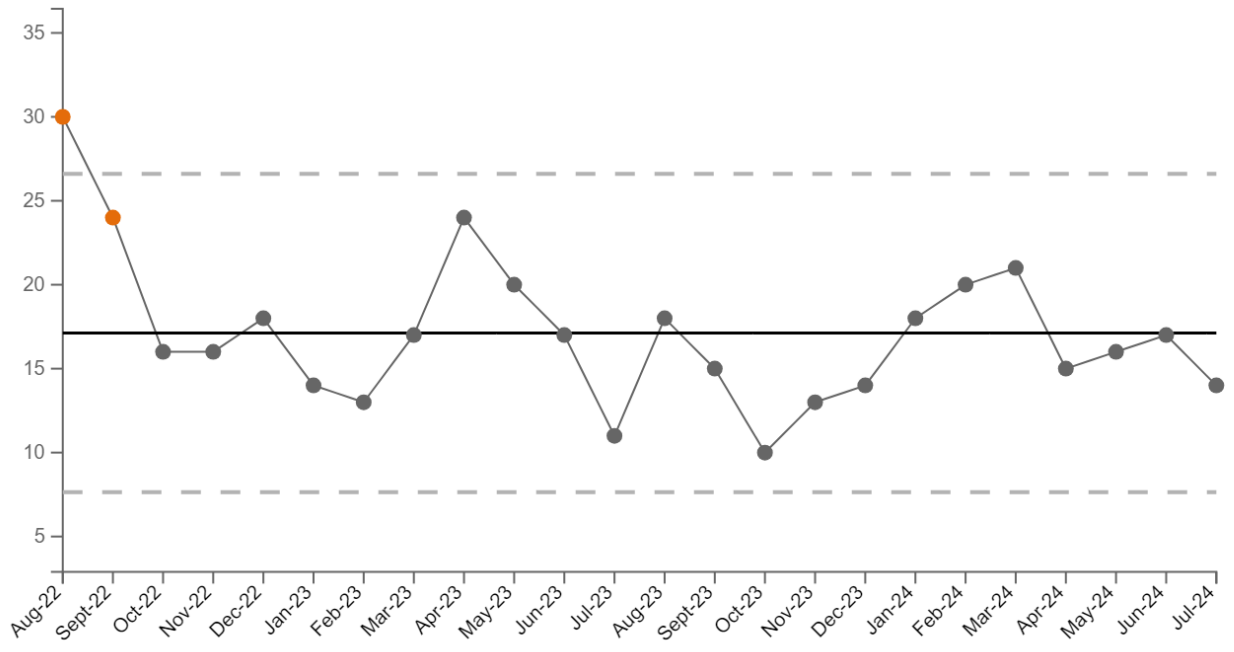
Continued reduction within yearly projections

Q03 Long term segregation and prolonged seclusion

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

Risk Rating: Med (Monitoring)

14	Not Applicable	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	Target	Variation	Assurance
Inpatient Care Group	12	n/a	Normal Variation	SPC n/a
Specialist Care Group	2	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There were 14 incidents reported in July 2024.

Root Cause of the performance issue

- Current cohort has significant numbers awaiting external accommodation/ transfer to higher levels of security

Improvement Actions

- Awareness and two day HOPEs training available, and inclusion of HOPEs principles included within PMVA training
- The Long-term segregation panel continues to review patients subject to long term segregation and pro longed seclusion on a weekly basis.
- Long Term Segregation and Prolonged seclusion panel to review and consider all alternatives.
- Group oversight of Clinically Ready for Discharge (CRFD) cases across all CBUs within Specialist Care Group to support access to appropriate placement and care packages
- Specialist Care Group reported a reduction in LTS with the successful ending of one case in Secure CBU following LTS Panel.

Expected impact and by when

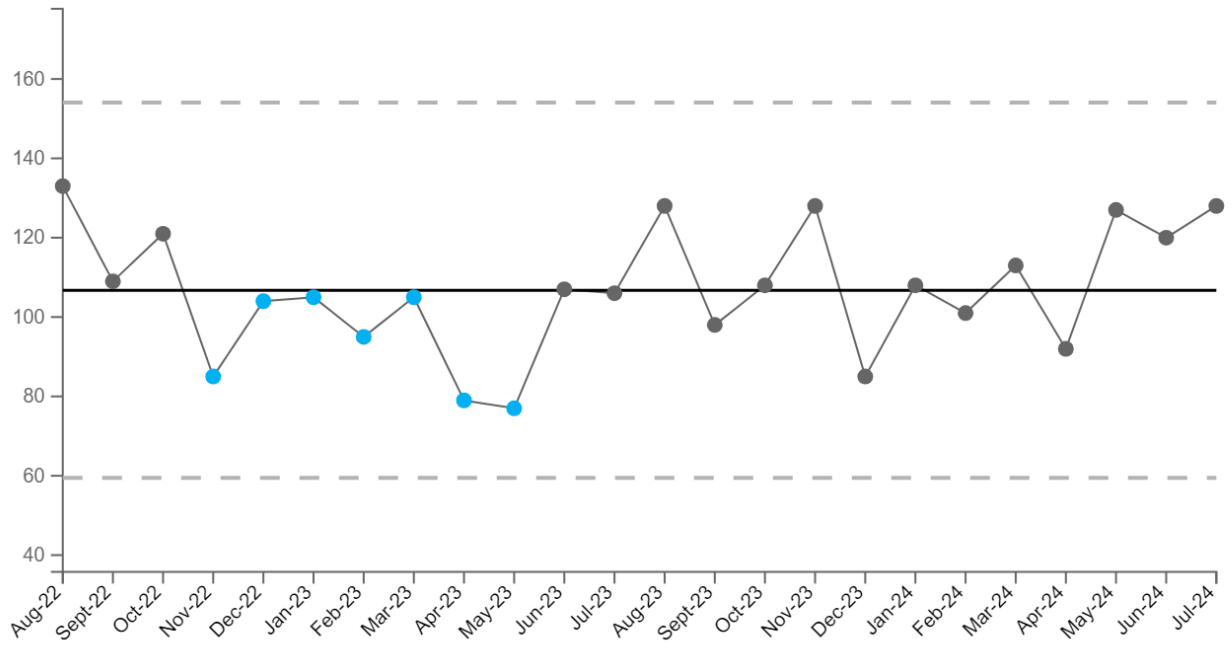
The system blocks remain outside CNTWs control therefore the Trust is dependent upon availability of specialised placements being made available/ built for those patients who require these placements.

Q04 Assaults on Patients

Number of Assaults on Patients

Risk Rating: Med (Monitoring)

128	Not Applicable	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



Breakdown of assaults on patients currently being reviewed to look at specific pathways and services – for example Older Persons, Adult Acute, Specialist CYP, LD&A and Secure. This will be included for August performance reporting period.

Feedback

What the chart tells us

There were 128 recorded incidents of assaults on patients during July.

Root Cause of the performance issue

- Of the 128 assaults in July 2024, 50% of the assaults involved no physical harm and 49% resulted in low physical harm with 1% (1 incident) classified as moderate physical harm.
- Between May and July 2024 Ruskin and Longview have the had the highest rates of incidents.
- We have seen a minor rise in assaults on patients in the last month, and in comparison, to July 2023, there has been a significant increase.
- High levels of acuity across the care groups
- Assault between patients featured more on male acute admission wards, PICU, Older Peoples wards and the Children's admission wards.

Improvement Actions

- The Violence reduction group met recently and started to scope the work plan going forward, including a review of aggression and violence incidents including hate crime, and this baseline data will be used as a measure as new guidance is implemented.
- Risk assessment and mitigation plans being introduced as part of policy change.
- Regular review of care plans and consideration of other environmental factors and care delivery approaches take place by the MDT.
- Embedding the debrief process including staff and patients to improve psychological safety.
- Four wards are involved in the NHSE Culture of Care programme where learning and good practice will be shared across all areas.

Expected impact and by when

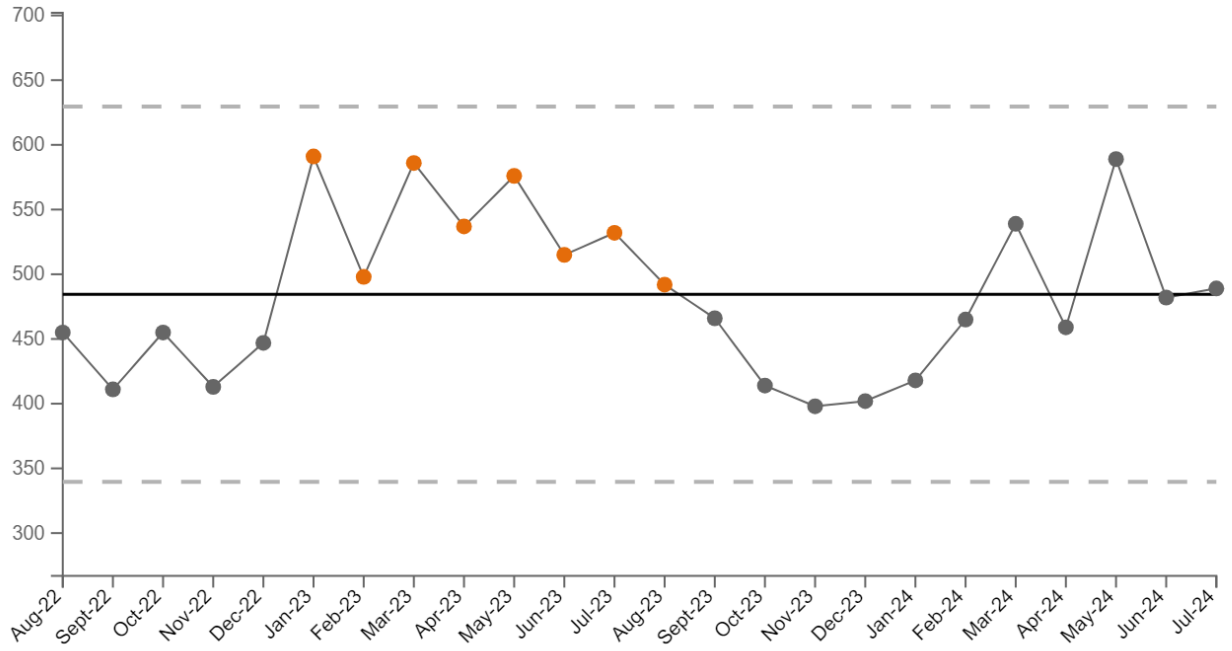
Monitoring of assaults on patients is reviewed following every incident and care planning, MDT review and updating of risk assessments is part of mitigation to prevent further harm, where there is known targeting between patients. This can be difficult where new incidents occur between patients for the first time, but this is built into risk planning after the event to minimise harm.

Q05 Assaults on staff

Number of Assaults on staff

Risk Rating: Med (Monitoring)

489	Not Applicable	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	Target	Variation	Assurance
Community Care Group	6	n/a	Normal Variation	SPC n/a
Inpatient Care Group	225	n/a	Normal Variation	SPC n/a
Other Care Group	0	n/a	Improvement	SPC n/a
Specialist Care Group	258	n/a	Normal Variation	SPC n/a
Support & Corporate	0	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There were 489 recorded incidents of assaults on staff during July which falls within the calculated expected range of 340 and 630.

Root Cause of the performance issue

- Assaults are comparable for the previous 2 months , whilst we have seen incident reporting increase significantly in the month of July from previous years, and the most incidents reported in any month ever.
- Of the 489 assaults, 225 (46%) of the harm was no harm, 250 (51%) are low harm, 14 (3%) are moderate harm, there were no severe harm incidents in July 2024.
- RIDDOR related activity has also dropped in July and is the 2nd lowest at 7 incidents since the concerns were raised to the HSE in December 2023.
- Whilst aggression and violence incidents generally have increased by over 26% on the previous year, assaults on staff by patients have decreased by 9.5% on the previous year.
- High areas of reporting continue to be Autism and Learning Disability Services, and Childrens Services, and in our recent focused inspection from the Care Quality Commission for Autism and Learning Disability in-patient services, there was a particular focus on physical intervention and assaults and injuries to staff.
- Incident proportions are closer distributed across pathways except for rehab (rehab seeing 11% of assaults on staff; 31% urgent care, 31% older peoples and 28% learning disability for in month).

Improvement Actions

- The violence reduction group has met recently, and considered are the improvement actions including improved guidance for staff to mitigate and respond to violence risk, this included a strengthening of all our governance policies that have a role to play in reducing violence.
- A workshop has been held that brought together over 60 front line clinicians and support staff to agree plans to improve our debrief processes and plans.
- PMVA drop-in sessions with specialist nurses within Specialist CYPS CBU
- RIDDOR Log, monitored via group safety meeting
- Four wards are involved in the NHSE Culture of Care programme where learning and good practice will be shared across all areas.

Expected impact and by when

Assaults on staff has been a key focus for the organisation and continues to be going forward as we implement improvements articulated in our response to the HSE improvement notice and PSIRF priority.

Assaults - Type of Harm

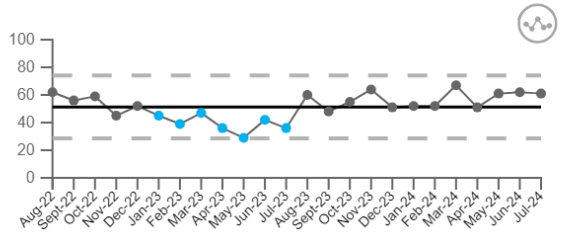
Reporting Period: Jul 2024

Assaults on Patients - Type of Harm

Assaults on Patients - No Physical Harm

Low (No Target)

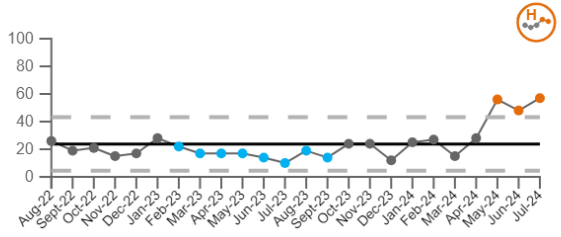
Ref: AP01 Performance: 61 Plan: n/a



Assaults on Patients - Low Physical Harm

Med (Monitoring)

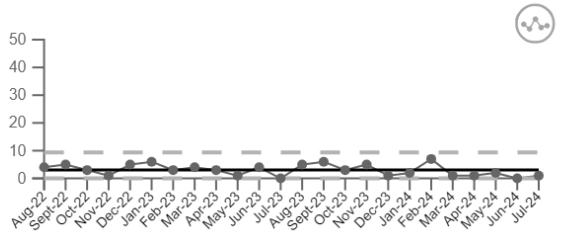
Ref: AP02 Performance: 57 Plan: n/a



Assaults on Patients - Moderate Physical Harm

Low (No Target)

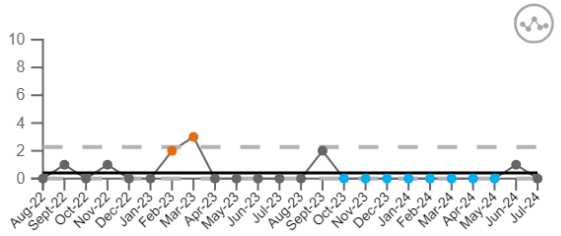
Ref: AP03 Performance: 1 Plan: n/a



Assaults on Patients - Severe Physical Harm

Low (No Target)

Ref: AP04 Performance: 0 Plan: n/a



In the last 24 months there have been 0 fatal assaults on patients

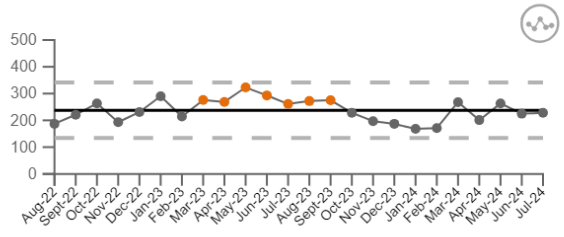
The system shows 0 assaults on patients over the last 24 months with no type of harm currently recorded

Assaults on Staff - Type of Harm

Assaults on Staff - No Physical Harm

Low (No Target)

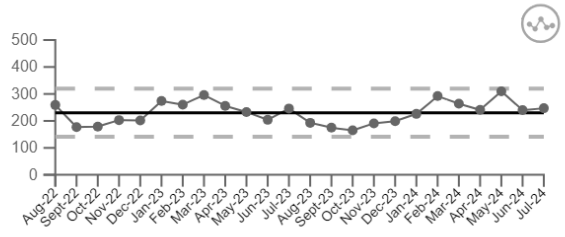
Ref: AS01 Performance: 228 Plan: n/a



Assaults on Staff - Low Physical Harm

Low (No Target)

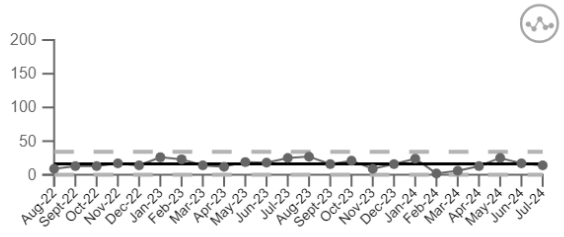
Ref: AS02 Performance: 247 Plan: n/a



Assaults on Staff - Moderate Physical Harm

Low (No Target)

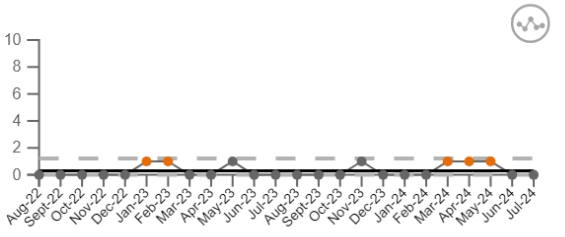
Ref: AS03 Performance: 14 Plan: n/a



Assaults on Staff - Severe Physical Harm

Low (No Target)

Ref: AS04 Performance: 0 Plan: n/a



In the last 24 months there have been 0 fatal assaults on staff

The system shows 0 assaults on staff over the last 24 months with no type of harm currently recorded

Q06 % of patients with a Safety Plan

% of patients with a Safety Plan

Risk Rating: Med (Monitoring)

tgt. = target n. = numerator d. = denominator

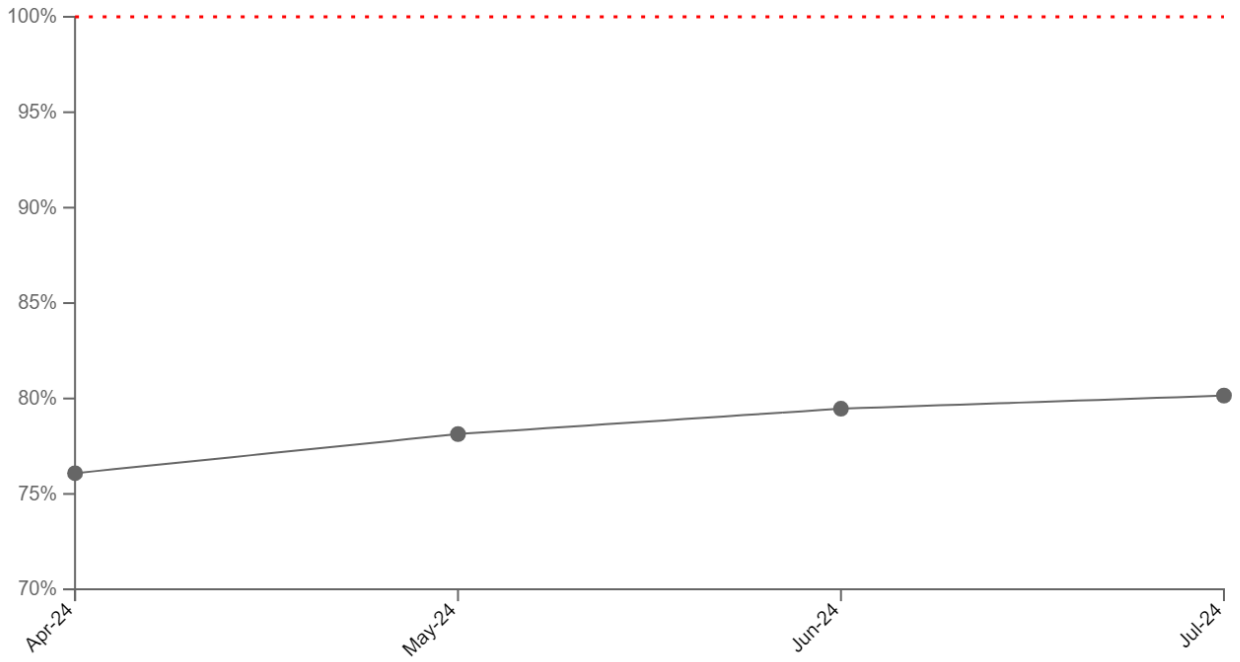
80.2% tgt. 100% n. 16,182 d. 20,189

Not Applicable

Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	78.0%	11,856	15,209	100%	SPC n/a	SPC n/a
Inpatient Care Group	93.2%	870	934	100%	SPC n/a	SPC n/a
Specialist Care Group	85.0%	3,275	3,855	100%	SPC n/a	SPC n/a
Support & Corporate	94.8%	181	191	100%	SPC n/a	SPC n/a

Feedback

What the chart tells us

In July 80.2% of patients were reported to have a Risk Management and Personalised Safety Plan.

Root Cause of the performance issue

- The new risk framework form went live on 8th April 2024. Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards.

Improvement Actions

- Community metric methodology is under review to ensure the correct patient group is being identified to be included in the metric.
- Embedding the framework
- Data quality report has been developed and is monitored by the Steering group. DQ issues are being raised regularly.
- Review of metric methodology taking place as part of the evaluation of the new framework (August 2024)
- New Risk policy is currently being developed
- Evaluation of the framework is under development
- Focus to improve medical training compliance in relation to biopsychosocial risk training.

Expected impact and by when

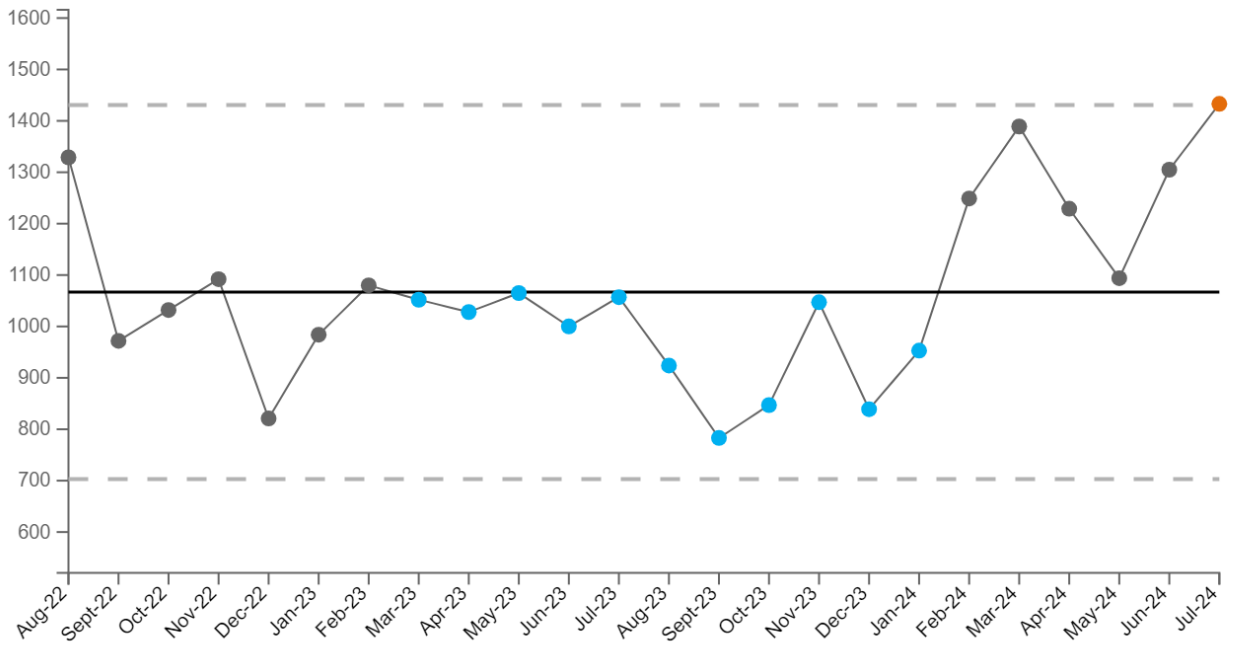
Evaluation planning commenced during June 2024 with recommendations for changes to form/metrics being suggested as part of this.

Q07 Reducing incidents of self-harm

Number of incidents of self-harm

Risk Rating: Med (Monitoring)

1,433	Not Applicable	Concern	DQ - No Concern
		There is concern because this indicator is increasing	There are currently no concerns with the data quality of this indicator



Care Group	Performance	Target	Variation	Assurance
Community Care Group	552	n/a	Concern	SPC n/a
Inpatient Care Group	455	n/a	Concern	SPC n/a
Specialist Care Group	425	n/a	Normal Variation	SPC n/a
Support & Corporate	1	n/a	SPC n/a	SPC n/a

Feedback

What the chart tells us

In July there have been 1,433 reported incidents of self-harm, the highest level reported within 24 months.

Root Cause of the performance issue

- 54% (773) of the incidents were no physical harm, 45% (641) were low physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm.
- Self-harm incidents continue to be a concern which require management focus in the short term. There are particularly high levels within our female facilities which account for 91% of the incidents within the acute pathway. Two wards continue to have high level of activity (Lamesley and Longview – activity on both wards accounted for 70% of all the self-harm incidents across the acute care pathway).
- In Specialist Care Group 68% of incidents of self-harm were reported within Specialist CYPS CBU

Improvement Actions

- Following these incidents debriefs occur which can be used to share learning across the inpatient care group.
- Requirement to establish a steering group and project management support
- Adopt and monitor the quality of biopsychosocial risk assessments with safety planning both on inpatient wards and within the community
- Review of observations
- Individualised care planning
- Review of patient care plans based on formulation is taking place where it is required.

Expected impact and by when

Ongoing monitoring 2024/25

Q08 Rights at Point of Detention

Key: Tgt = Target, n = Numerator, D = Denominator

Risk Rating: **High (Action)**

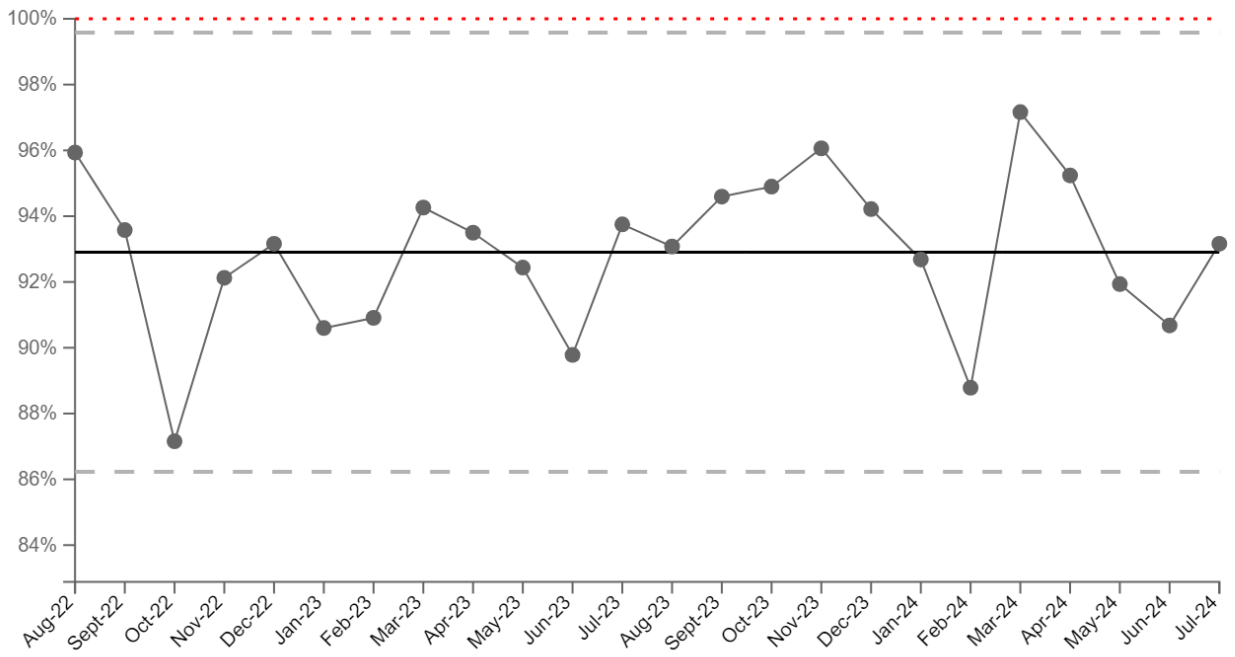
Number of clients (Detained) whose detention has started within the reporting period and there is a Record of Rights Given (detained/CTO) - Form H3L within 7 days either side of the detention starting

93.2%	tgt.	100%
	n.	109
	d.	117

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	93.3%	98	105	100%	Normal Variation	Consistently Off Target
Specialist Care Group	91.7%	11	12	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Compliance in this area continues to fluctuate and is reported for July at 93.2%.

Root Cause of the performance issue

- Staff on the ward may not be aware of our duty to give a person their rights when detained and the requirement to review rights.
- Significant number of pertinent requirements to be complete at the point of admission.
- Availability and consistency of training.

Improvement Actions

- 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.
- MHL specialist participates in CQC mock visits and reviews compliance in this area and feeds back to the clinical team.
- 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 developed and on intranet.
- The MHLSG meet quarterly to discuss the giving of patients' rights, this will be raised within the Care Groups monthly and actions reported back through the Steering Group for assurance.
- Increase compliance in MHA, MCA and DOLS training (impacted by cancelled courses).
- Developed rights on a page poster (outlines key duties in relation to the reading of rights).

Expected impact and by when

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

Q09 Record of Capacity/ CTT at point of detention

Risk Rating: High (Action)

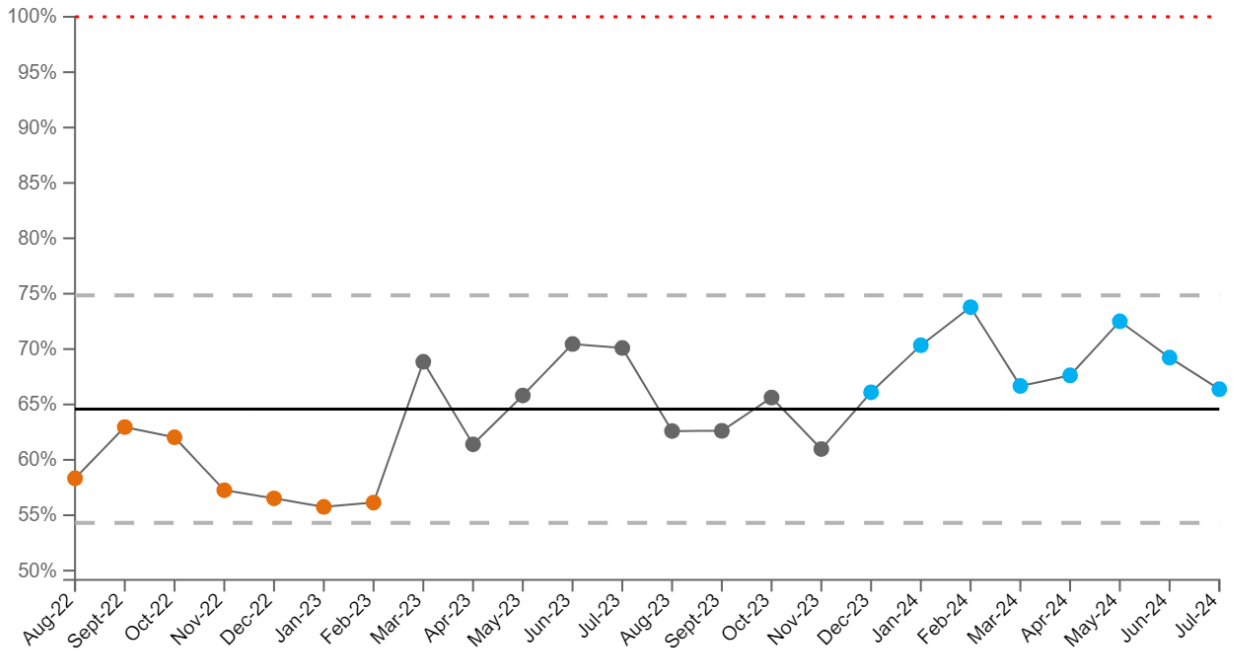
Number of Clients with a Record of Capacity/CTT for Detained Clients forms with Part A completed within 7 days either side of the 3 Month Rule starting date. **Key:** Tgt = Target, n = Numerator, D = Denominator

66.4%	tgt.	100%
	n.	77
	d.	116

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	65.4%	68	104	100%	Normal Variation	Consistently Off Target
Specialist Care Group	75.0%	9	12	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

July compliance is reported at 66.4% 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 (RC) to complete the form
- Local form rather than legal requirement (legal requirement at 3 months).

Improvement Actions

- Group Directors for each locality have been tasked to look at different ways to improve compliance.
- MHL specialist participates in CQC mock visit and reviews compliance in this area and feeds back to the clinical team.
- MHL Specialist to attend the quality standards groups for inpatients and community to report on compliance around record of capacity at point of detention.
- Gain understanding in relation to difficulties from RCs why the timeframe cannot be met
- The MHLSG meet quarterly to discuss the giving of patients' rights, this will be raised within the Care Groups monthly and actions reported back through the Steering Group for assurance
- Presentation from MHA office at consultant meetings.
- MHA office continue to prompt Responsible Clinicians (RC) to complete this form at point of detention.
- Discussed in a number of medical/ consultant meetings to raise awareness and focus.

Expected impact and by when

- We would expect to see improvement 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)

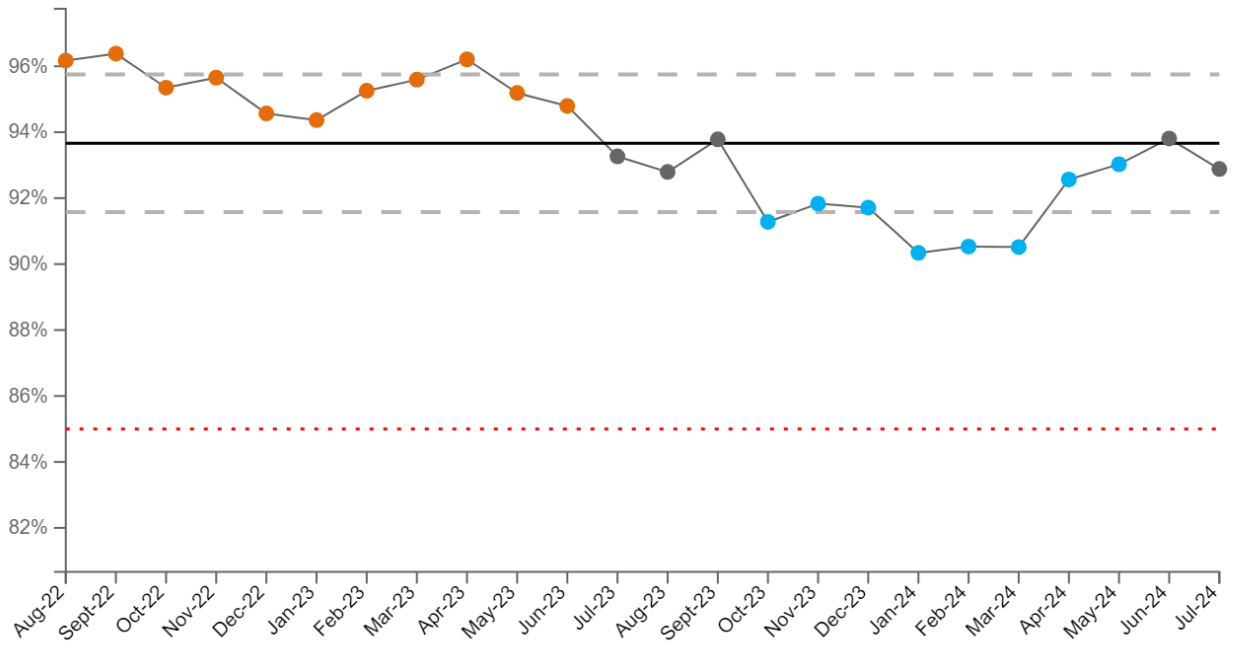
tgt. = target n. = numerator d. = denominator

92.9% tgt. 85% n. 20,973 d. 22,580

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	100.7%	14,862	14,754	85%	Normal Variation	Consistently Off Target
Other Care Group	0.0%	0	0	85%	Improvement	Achieve at Random
Specialist Care Group	78.1%	6,111	7,826	85%	Improvement	Achieve at Random

Other Care Group relates to wards that were closed prior to new operational structure and will continue to show for next 20 months

Feedback

What the chart tells us

Bed occupancy was reported at 92.9% in July, remaining 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 extended for a further 6 months until January 2025). Mitford Bungalows remains empty in terms of beds until the review work is concluded but the beds are included within the overall occupancy level.
- Reporting is based on open beds on Rio, beds may be left open and included in reporting affecting occupancy levels.- Secure care currently have open RiO beds, however these are being utilised to support bespoke care packages, and not currently commissioned.
- 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

- Following a review, local / locality discharge facilitation teams now form part of EBM which will help promote standard work and flow.
- Implementation of admission and discharge policy (draft policy specific for older people's inpatients developed).
- System wide working with third sector.
- There is significant oversight of the beds currently out of use.
- The ICB has confirmed the 24/25 (and 25/26) allocations for Providers in relation to Inpatient Quality Transformation (IPQT)and Crisis Service Development Funding (SDF). The Group are developing the proposals / investment plans which align with the NENC IPQT plan and support the effective use of the inpatient bed stock.

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

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

Risk Rating: Med (Monitoring)

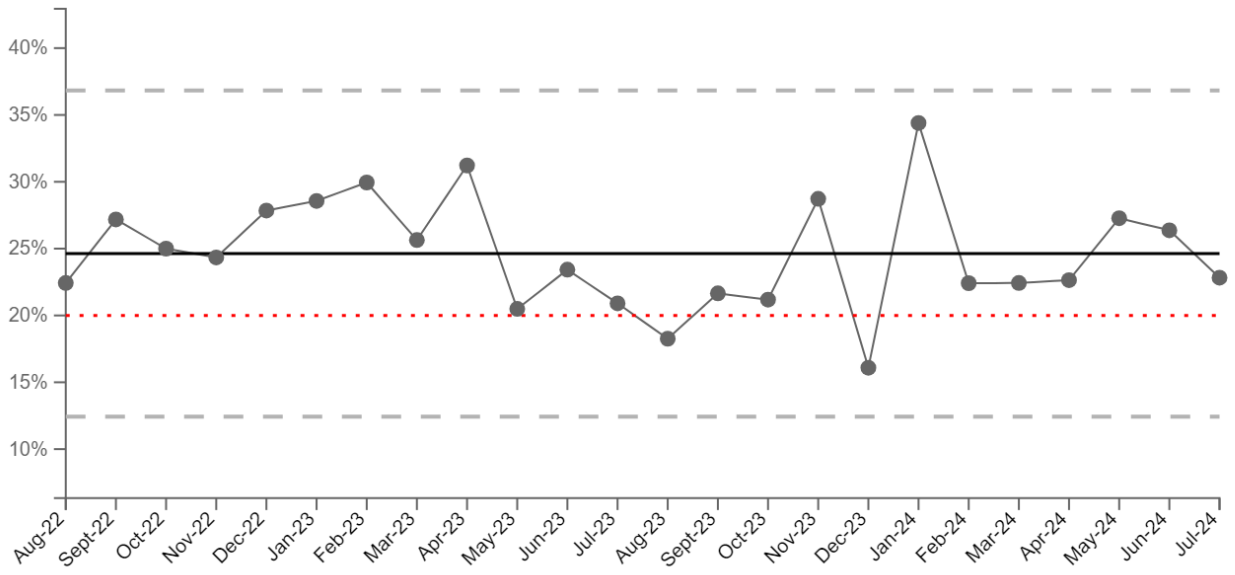
tgt. = target n. = numerator d. = denominator

22.8%	tgt.	20%
	n.	21
	d.	92

Achieve at Random
The target 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



Place Team	Perf	N	D	Target	Variation	Assurance
Central Inpatient CBU	19.2%	5	26	20%	Normal Variation	Achieve at Random
North Cumbria Inpatient CBU	15.4%	4	26	20%	Normal Variation	Achieve at Random
South Inpatient CBU	20.0%	4	20	20%	Normal Variation	Achieve at Random
North Inpatient CBU	36.8%	7	19	20%	Normal Variation	Achieve at Random
Neuro Rehabilitation & Specialist Services CBU	100.0%	1	1	20%	SPC n/a	SPC n/a

Feedback

What the chart tells us

In July 22.8% 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

- High levels of risk and need evidenced by high detention rates within the acute wards (circa 83% of patients detained).
- Medication changes and stabilisation (treatment resistant cohort).
- Increasing number of learning disability and autism patients
- Periods of leave to facilitate successful discharge into the community.
- Delayed discharges due to challenging and complex presentations and limited appropriate housing and or social support.

Improvement Actions

- Focus on patient discharge from admission
- Meetings are in place with the local authorities to review those who are Clinically Ready for Discharge (CRFD)
- Daily huddles are underway.
- Enhanced MDT work being progressed to improve the therapeutic offer.
- Discussions to commence/ re-commence a focused Clinically Ready for Discharge (CRFD) system meeting (focus on made events).
- In-reach model
- Consistent approaches to Care Treatment Reviews (CTRs)

Expected impact and by when

It is expected that LOS will improve over summer 2024.

A05 Clinically Ready for Discharge (formerly DTOC)

Key: Tgt = Target, n = Numerator, D = Denominator

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)

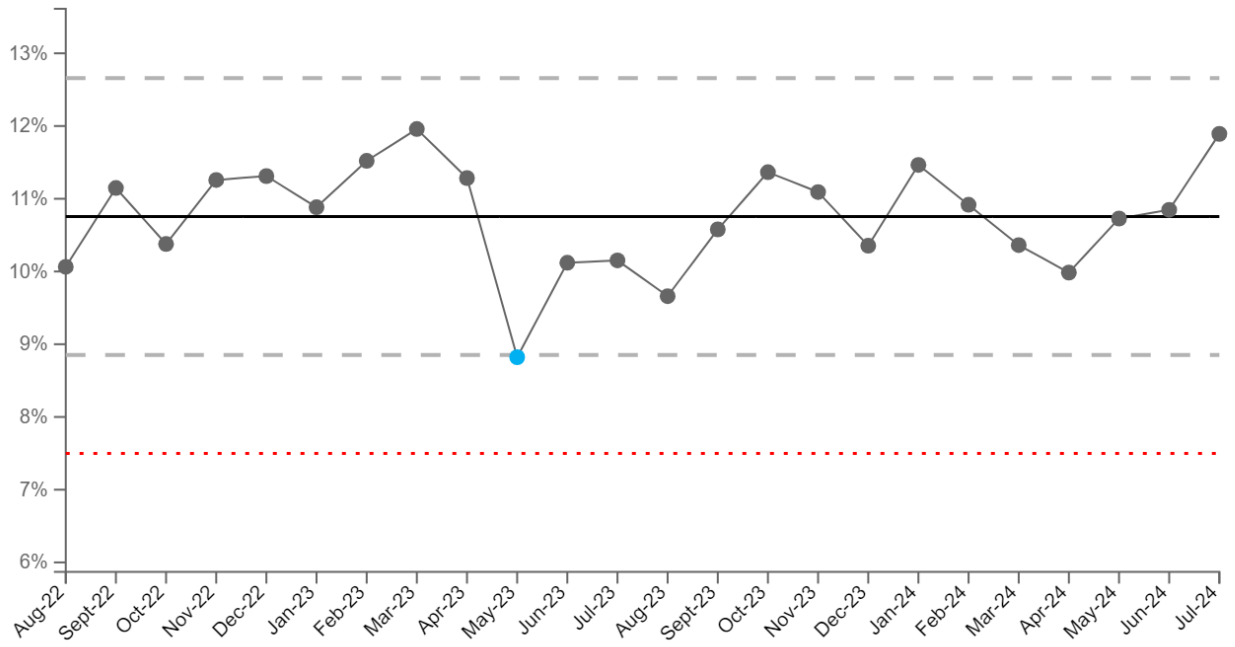
11.9%

tgt. 7.5%
n. 2,143
d. 18,021

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	12.9%	1,915	14,803	7.5%	Normal Variation	Consistently Off Target
Specialist Care Group	7.1%	228	3,218	7.5%	Improvement	Achieve at Random

Feedback

What the chart tells us

In July 11.9% of patients were Clinically Ready for Discharge (CRFD). Within CYPS 18.8% of current patients at 31.07.24 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

- Dedicated focus by senior case manager to review and support discharge plans for those CRFD
- Weekly 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 March 24/25 through Better Care Fund (BCF) monies.
- The Group has been approached by Cumberland Council to participate in a review of the residential nursing homes to increase and improve their knowledge and competencies in manging people with dementia.
- Following a review, local / locality discharge facilitation teams now form part of Enhanced Bed Management (EBM) which will help promote standard work and flow.
- Discussions to commence/ re-commence a focused CRFD system meeting (focus on made events)

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

tgt. = target n. = numerator d. = denominator

29.3%

tgt.	60%
n.	53
d.	181

Achieve at Random

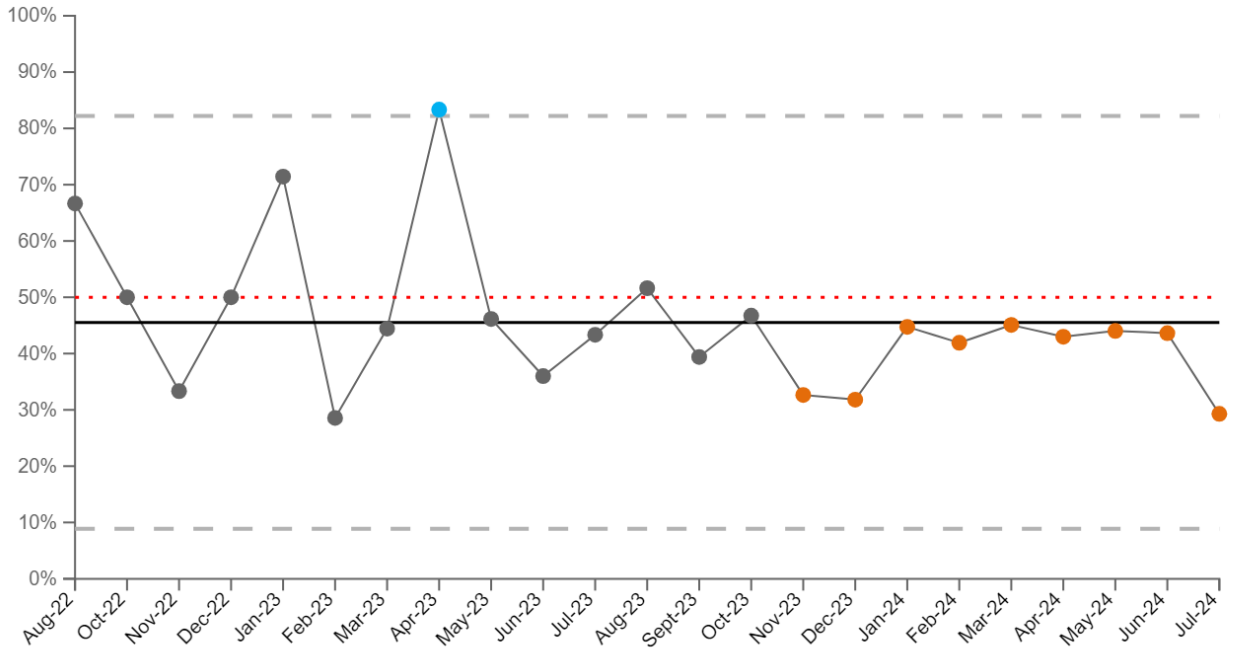
The target for this indicator is within the upper and lower control limits

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Place Team	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	21.0%	29	138	60%	Concern	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	44.4%	8	18	60%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	64.0%	16	25	60%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Very urgent referrals seen within 4 hours achieved 29.3% in July, the lowest performance since February 2023.

Root Cause of the performance issue

- Inconsistencies across locality in Very Urgent referral recording and accuracy of contact recording, see denominator for each place.
- 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)

- Staffing shortages particularly with Band 6s.
- Triage system being reviewed to reduce missed opportunities for contact with patients.
- 136 staffing model and the impact on the crisis service.

Improvement Actions

- Daily Sitrep reporting in place for Crisis services regarding staffing levels, currently crisis staffing is challenging across all localities, with a specific focus on Newcastle & Gateshead.
- Consideration for process when high levels of temporary staffing are used to support capacity to ensure methodology continues to be followed.
- Review metric definition in line to ensure reporting is in line with national methodology
- Peer review of referrals urgencies via Access Oversight sub-group
- Standardisation of referral recording and staff supported to correct data quality issues
- Development of crisis triage hub will reduce variation in referral urgencies.
- Referral urgency guidance has been revisited with Newcastle Gateshead crisis team and will be utilised.

Expected impact and by when

Expected continued improvement across Quarter 2 2024.

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

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

Risk Rating: Med (Monitoring)

tgt. = target n. = numerator d. = denominator

82.8%

tgt.	85%
n.	322
d.	389

Achieve at Random

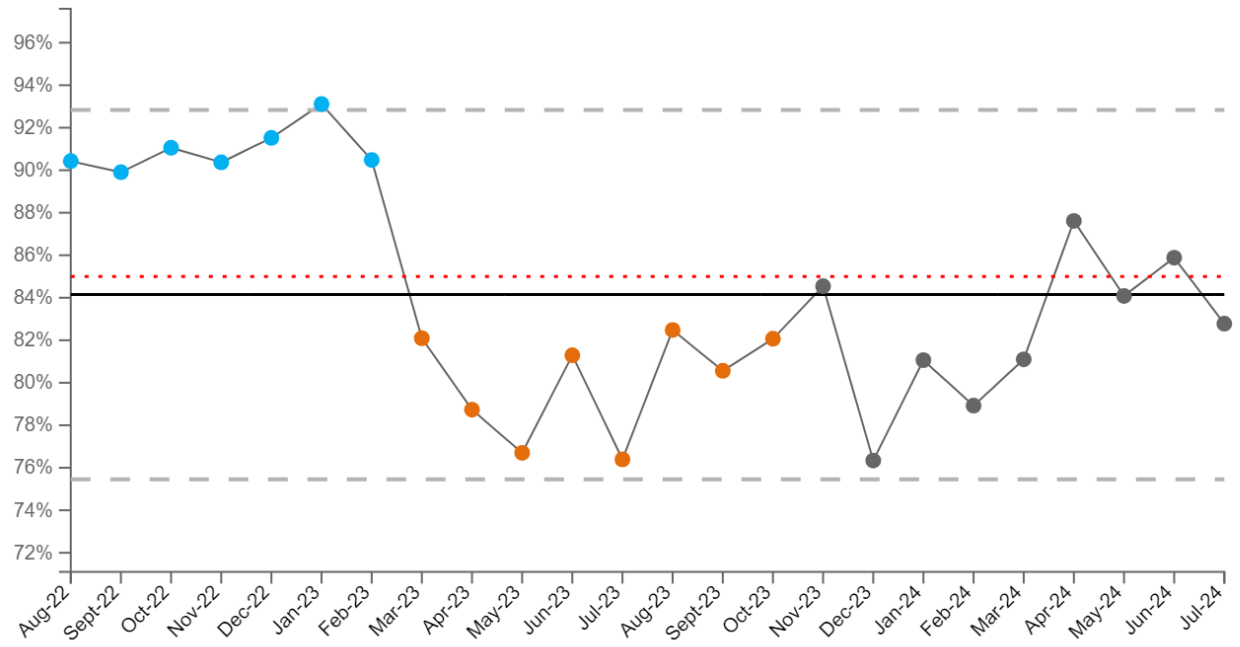
The target for this indicator is within the upper and lower control limits

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	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	71.4%	25	35	85%	Normal Variation	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	78.4%	160	204	85%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	91.3%	137	150	85%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Urgent referrals seen within 24 hours achieved 82.8% in July

Root Cause of the performance issue

- Staffing shortages particularly with Band 6s.
- Inconsistencies across locality in Urgent referral recording and accuracy of contact recording, see denominator for each place.
- 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.
- ICTS providing input to ED in areas where there is no CYPS PLT.

Improvement Actions

- Daily Sitrep reporting in place for Crisis services regarding staffing levels, currently crisis staffing is challenging across all localities.
- 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
- Review metric definition in line to ensure reporting is in line with national methodology
- 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 2 2024.

A08 % PLT ED Referrals seen within 1 hour

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

Risk Rating: **Med (Monitoring)**

tgt. = target n. = numerator d. = denominator

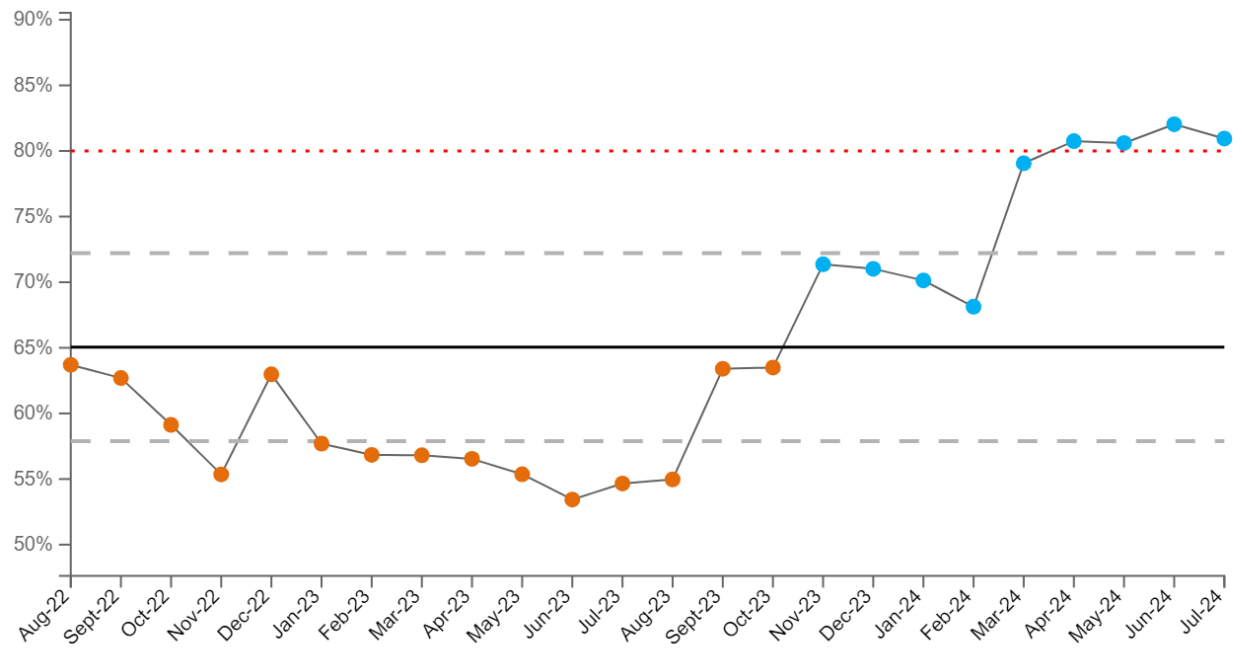
80.9%

tgt. 80%
n. 875
d. 1,081

Consistently Off Target
The target 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	Perf	N	D	Target		Variation		Assurance
Newcastle & Gateshead Place Team	71.5%	304	425	80%		Improvement		Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	80.4%	296	368	80%		Improvement		Consistently Off Target
Sunderland & South Tyneside Place Team	95.5%	275	288	80%		Improvement		Achieve at Random

Feedback

What the chart tells us

Performance was 80.9% in July which is above the expected range.

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
- Commissioned resource does not meet demand for a 1-hour response at busy times during the evening and nights.

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.
- 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)

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

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

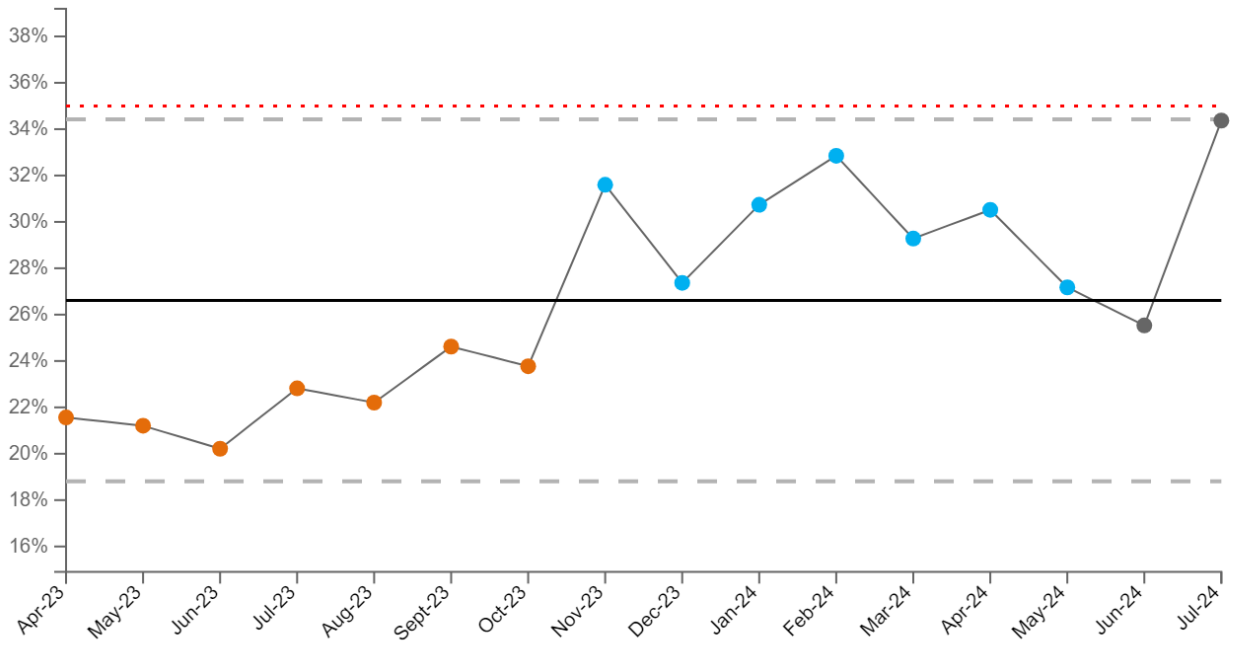
34.4%

tgt. 45%
n. 796
d. 2,316

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	36.0%	754	2,092	45%	Improvement	Consistently Off Target
Specialist Care Group	18.8%	42	224	45%	Normal Variation	Consistently Off Target

Feedback

What the chart tells us

Performance increased to 34.4% in July.

Root Cause of the performance issue

- The number of patients starting treatment is lower than the number of referrals in the latest 4-week period.
- There are several patients waiting over 4 weeks to start treatment, this impacts new referrals which are waiting.

Improvement Actions

- A significant amount of work underway to embed new pioneer process alongside data quality work to ensure the position is accurately reflecting operational delivery.
- Weekly steering group has been re-established in Community CBU
- Fortnightly waiting list meetings overseen by each team.
- Weekly waiting times oversight meetings re-established with CBU's reporting back monthly.
- Work on data quality and recording is a focus area, ensuring that all elements linked to treatment beginning have been completed.
- We are working to ensure that we are not restarting waiting time once a patient has accessed treatment by improving the knowledge and understanding for how the waiting time methodology works.

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)

Risk Rating: High (Action)

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

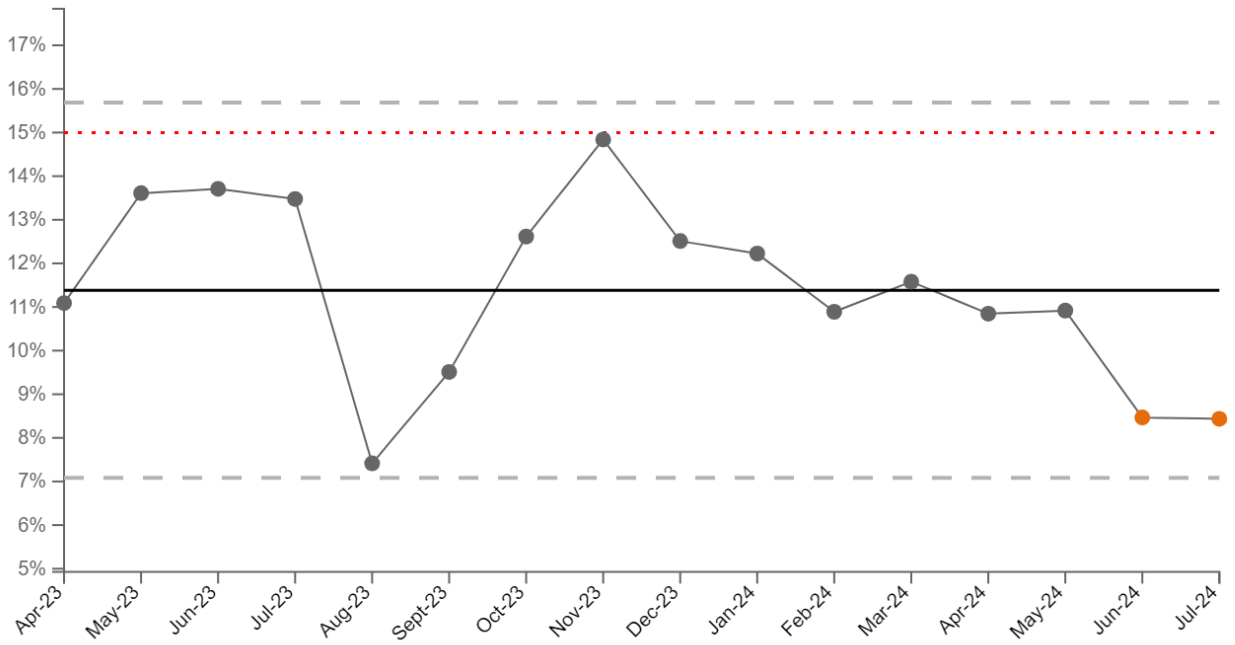
8.4%

tgt. 25%
n. 540
d. 6,400

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

Concern
There is concern because this indicator is decreasing

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



Place Team	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	5.2%	246	4,740	25%	Concern	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	15.3%	245	1,606	25%	Normal Variation	Consistently Off Target
Sunderland & South Tyneside Place Team	90.7%	49	54	25%	Improvement	Consistently Achieve

Feedback

What the chart tells us

Performance deteriorated in the month. 8.4% of referrals have been waiting 4 weeks or less to receive help. Overall, a total of (5,953 out of 6,400) 93.0% waiters are within the neurodevelopmental pathway.

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 model 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.
- Central CYPs in discussion with partners around 'welcome events'
- Central - Toby Henderson Trust has been commissioned to continue to support ASD assessments and welcome events using ICB funding.

Expected impact and by when

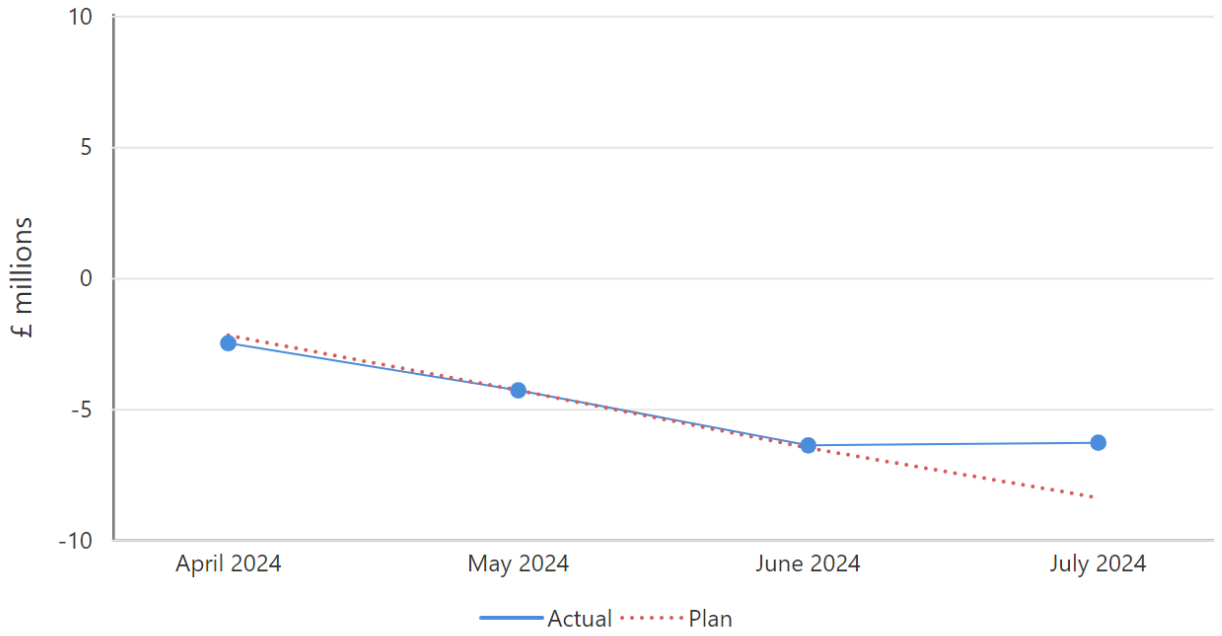
There is a national focus on neurodevelopmental pathways, which has recognised the amount of demand for diagnosis and how we approach meeting neurodevelopment needs. It is expected that the demand for diagnosis will continue throughout 2024, the expected impacted of actions will be to mitigate the increasing 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)

-£6.3m	Plan -£8.4m	Not Applicable	Not Applicable	DQ - No Concern: There are currently no concerns with the data quality of this indicator



Care Group	Actual	Plan	Variation	Assurance
Community Care Group	£15.9m	£16.4m	SPC n/a	SPC n/a
Inpatient Care Group	£2.8m	£5.4m	SPC n/a	SPC n/a
Specialist Care Group	£9.5m	-£4.7m	SPC n/a	SPC n/a
Support & Corporate	-£34.5m	-£25.5m	SPC n/a	SPC n/a

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 / worsen the financial forecast. A upside and downside scenario is being prepared.
- 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 COMMUNITY HUB ? WEST CUMBERLAND UPDATE

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

3.1 Board Paper re 247 hubs NHSE update Aug 24RD.pdf

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Name of meeting	Board of Directors Meeting
Date of Meeting	Wednesday 4 September 2024
Title of report	NHS England's Quality Transformation Programme's Mental Health 24/7 community pilots programme (Update)
Executive Lead	Ramona Duguid – Chief Operating Officer
Report author	Stewart Gee – Director of Safety, Security, Resilience & Trust Innovation

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

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

Meetings where this item has been considered		**Management meetings where this item has been considered**	
Quality and Performance		Executive Team	x
Audit		Executive Management Group	
Mental Health Legislation		Business Delivery Group	
Remuneration Committee		Trust Safety Group	
Resource and Business Assurance		Locality Operational Management Group	
Charitable Funds Committee			
People			
CEDAR Programme Board			
Other/external (please specify) Community Transformation Programme Board	X		

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

Board of Directors Meeting
Wednesday 4th September 2024

NHS England's Quality Transformation Programme's Mental Health 24/7 community pilot's programme Expression of Interest (Update)

1. BACKGROUND

In April 2024 NHS England (NHSE) invited Providers and Systems to submit bids to be included in NHS England's Quality Transformation Programme's Mental Health 24/7 community pilot programme by 24 May 2024. The Programme allows providers and systems to explore the opportunity for open access, 24/7 community services closer to home for people who are experiencing significant mental health difficulties. This will go some way to ensuring that people can maintain continuity of care and a sense of citizenship and belonging while receiving treatment, rather than the dislocation that is often a secondary feature of treatment for people who have to move out of their area to access inpatient care.

Central to the pilot programme are a set of principles, created in conjunction with people with lived experience, and based on international comparators who operate similar systems of support. Adherence to these principles, readiness to move to a new model and systemic integration are the key factors that will be used to identify pilot sites for funding through a full and fair process. Involving people with lived experience, as well as multiagency partners is central to creating a pilot project that can be successful in receiving financial support from the programme. NHSE are looking to support projects in a range of settings and localities, testing the model across the range of areas that represent mental health services in England.

Projects receiving funding are to be externally evaluated to create a body of evidence regarding the operational utility and patient experience for those using pilot services. Feedback from this ongoing evaluation will be shared with the network of pilot and associate sites to speed up the iterative changes that will support Mental Health services to identify strengths and challenges of the new model.

This paper summarises for the Board the successful bid which has now been confirmed for Whitehaven in West Cumbria.

2. CNTW BID

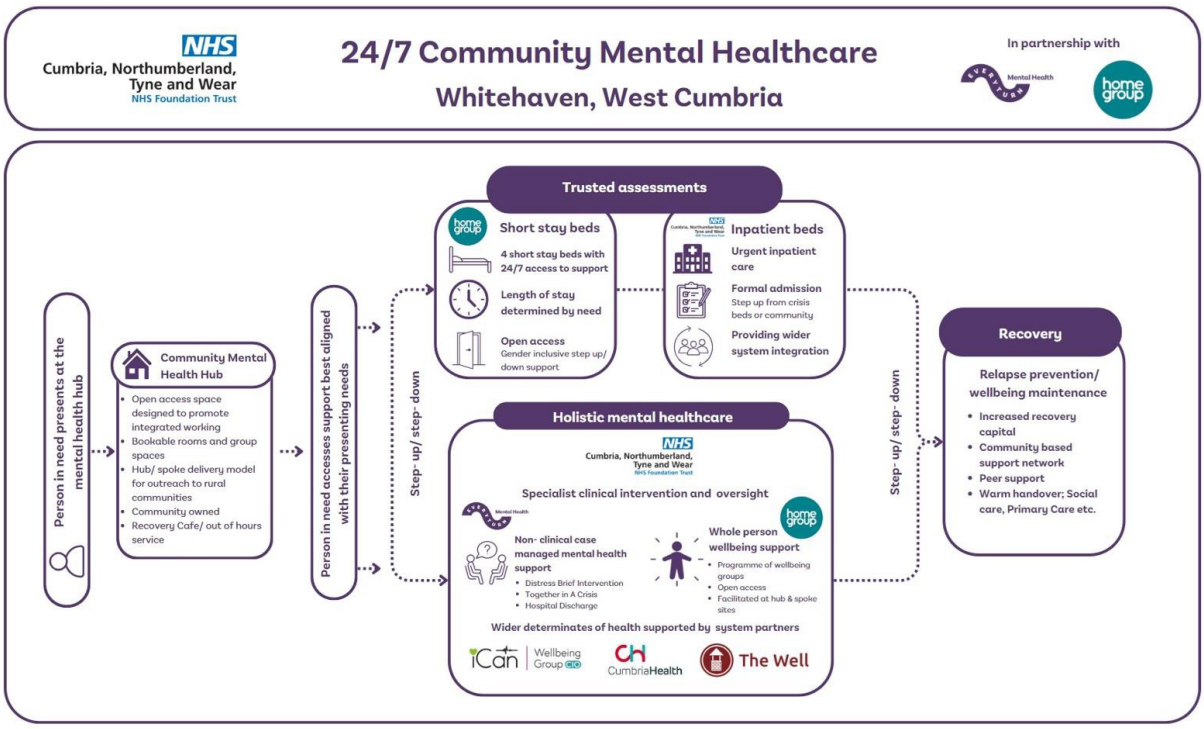
During April 2024 work was progressed to prepare to bid supporting the work to implement the model of care ambitions as part of community mental health transformation.

It was agreed that Whitehaven would be the chosen place for the bid for the following key reasons:

- Copeland Primary Care Network, with a population of 62,432, encompasses both the western Lake District and more densely populated, socio-economically deprived and isolated coastal areas.
- Copeland has the highest suicide rate in England. At 20.6 per 100,000 in 2020-22, double the national rate. Other factors also include:
  - High levels of depression - 18% compared to 13% in England, QOF, 2020/23
  - Drug related poisoning mortality- 8 of 309 ONS, 2020-22
  - Referrals to community mental health services have trebled between 2017 and 2023.

The bid was developed in partnership with Everyturn Mental Health and HomeGroup, working alongside Service Users, Carers, Families, partner organisations and communities from Whitehaven and Workington. Partners from across primary, third sector and social care will work together to deliver the ambitions set out in the bid. An illustration of the integrated hub is outlined in figure 1 below.

Figure 1:



The bid for Whitehaven focusses on the development of a truly integrated model for mental health care which will transform how local communities access help and support. The integrated hub will provide:

- Alternative to hospital admission with 4 short stay beds
- Recovery café with intensive support
- CNTW specialist support for people with on-going complex needs without requiring re-referral
- Holistic education & advice e.g. housing, money & employment
- Physical health advice & monitoring
- Peer, family & carer support
- Access to Recovery College and local community assets
- An integrated NHS, LA and VCSE 'team around the person' approach
- Enhance continuity of care

The Bid Team were Advised on 10th July the bid had been successful and awarded £4.3 million non-recurring funding for 2 years to be awarded as £2,150,000 per year. NHS England (NHSE) announced the confirmation of the successful bids on Friday 23rd August 2024.

NHSE received 36 bids from across the country with 6 successful sites in the below inner city and rural locations:

- **Whitehaven** ran by Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust
- **York** ran by York Mental Health Partnership
- **Birmingham East Central** ran by Birmingham and Solihull NHS Foundation Trust
- **Tower Hamlets** ran by East London Foundation Trust
- **Lewisham** ran by South London and Maudsley NHS Foundation Trust
- **Sheffield** ran by Sheffield Health and Social Care NHS FT.

2.1 Next steps

Programme governance is in place with the Executive lead, Senior Responsible Officer and Trust Innovations supporting delivery of the aims of the 24-7 hub.

A steering group has been established to begin mobilisation of the model. The group have agreed to meet monthly in Whitehaven with membership including representation from all partners and Service User and Carer representatives.

The team are also establishing a core implementation group focussing on several initial workstreams, including:

- Estates (securing a building for the hub)

- Recruitment
- Branding
- System and Process mapping
- Promotion including communication and engagement
- Information Recording System
- Evaluation, Reporting and Assurance

Milestones across the key delivery areas will be developed with partners to achieve effective implementation and assessment of impact. Work to ensure stakeholder briefings and engagement is in place has also commenced.

3. CONCLUSION & RECOMMENDATION

Achieving success with this bid and the investment it brings to Whitehaven will be truly transformational. The ambition set out in the model of care which will be delivered with partners will challenge traditional ways of working and support truly joined up approaches to meet the needs of the local community.

The Board are asked to NOTE the report and associated delivery which is now being mobilised with partners.

Chloe Mann – Place Director, North Community
Stewart Gee - Director of Safety, Security, Resilience & Trust Innovation

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

Ramona Duguid, Chief Operating Officer

4. STRATEGIC AMBITION 3 - A GREAT PLACE TO WORK

Darren Best, Chair

4.1 PEOPLE COMMITTEE REPORT

Brendan Hill, Committee Chair

For Assurance

REFERENCES

Only PDFs are attached

4.1 People Committee Assurance Report September 2024.pdf

Board Committee Assurance Report
Board of Directors Meeting
Wednesday 4 September 2024

Name of Board Committee	**People Committee**
Date of Committee meeting held	31 July 2024
Agenda items/topics considered	See below
Date of next Committee meeting	30 October 2024

1. Key areas of focus:

- Chair's Business

  The Chair of the Committee commented on the first workshop held on 26 June 2024 which had a focus on retention, employee relations and just culture. Feedback from the workshop was positive. The workshop on 27 November will include an update on the priorities outlined in the Great Place to Work ambition of the Annual Plan, including OD and progress around workforce establishment planning.

  The Chair also commented on the key areas of focus for the Committee for the next few months which are linked to the Trust Annual Plan. These are the areas where he would like the Committee to demonstrate meaningful progress by the end of 2024/25. The key areas are:

  - How our work on 'just culture' is being embedded
  - Workforce establishment planning
  - Leadership development
  - Improving performance on revised staff training targets
  - Review how service user and carer views influence our priorities and work programme

- Workforce Performance Report – **discussion and assurance**
- Guardian of Safe Working Hours Quarterly Report **- assurance**
- EDI Action Plan 2024/25 – **assurance**
- Employee Relations Annual Report – **discussion**
- Medical Revalidation Report – **update and agreement to approve outside of formal meeting**
- WRES / WDES Annual Report – **discussion and assurance**
- CPD Allocation – **to note**
- 2024 People Committee Review of Performance against ToR - **discussion and approval**
- Health and Wellbeing Steering Group Terms of Reference – **to note**
- 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.

Clinical supervision

Action from previous meeting: 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. (To update 31 July 2024)

The task and finish group set up to review the way supervisions are carried out and recorded continues to meet. There is a significant improvement in compliance since the last meeting on 1 May 2024, however, it is acknowledged there is still some work to do to consistently meet the target. This remains an area of focus for the CQC and part of the Trust's CQC Must Do actions. Whilst the governance of this item remains with Q&P, the ongoing work on supporting improvement will remain in our performance reports along with appraisal and related training priorities.

Staffing Establishments

Action from previous meeting: Workforce Plan and establishments to be reviewed in line with changes to the clinical model and forms part of the annual plan priorities. (To update November 2024)

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. The plan to review the establishments and progress of the workforce plan is still on track for November's workshop.

Local Onboarding

Action from previous meeting: Corporate and Local Induction to be included in future Workforce Performance Reports (to update July 2024)

This action has now been completed.

There have been two onboarding internal audits in recent months (one for temporary and one for substantive staff). Both reports showed some gaps in assurance. Remedial action is progressing, and it was agreed to provide a paper for the October meeting to show progress against all actions raised as part of the two audits (Update October 2024)

Sickness

Provisional sickness figures have increased from those reported at the previous meeting. There has been an increase in Covid 19 nationally over recent weeks and there have been a number of staff absences due to this.

Continued focus has been given to support staff to stay at work in terms of reasonable adjustments etc. A task and finish group has been set up to review the current provision. The regional wellbeing hub continues to provide a service to providers across the region in terms of mental health support. The Trust internal Staff Psychological Centre is experiencing some capacity issues (as reported in April 2024) and there is an estimated 6 month waiting list currently. The team is having an Away Day in September facilitated by CNTW Innovations to

review the model and this will be discussed at a future BDGW with feedback through to the People Committee in due course.

Employee Relations

Creating a compassionate, just and learning culture has an impact on staff wellbeing, patient safety, a sense of psychological safety which in turn will reduce sickness absence, turnover and the number of investigations. This is a key BAF risk aligned to Strategic Ambition 3.

This was a topic area for the June workshop where detailed discussion took place. It was further discussed at the People Committee where the key points within the Capsticks HRA Annual Report were summarised. This included:

- An overall reduction in the number of cases.
- A significant reduction in the number of formal cases, in particular compared to the previous year.
- An improved position in the number of open cases as many longstanding cases have come to a conclusion.
- There remains a challenge around timescales and the report details that only one grievance and no disciplinaries were concluded within the timescales outlined in policies over the last year.

The Committee was advised that there has been a focus on timescales over the last quarter and several mechanisms are in place including having an Exec and Director Lead on long-standing cases.

In terms of just culture, this was a focus at the last Trust Leadership Forum. The National NHS Just Culture Framework has been in place for some time, and this is a key priority for Strategic Ambition 3 for this year. The Disciplinary policy will be reviewed in the coming months to ensure just culture principles are a key element. The Grievance policy is currently being reviewed with a focus on resolution rather than grievance.

The Trust Trauma Informed Approach Lead is working with the workforce team to ensure TI principles are embedded throughout workforce policies.

Equality Diversity and Inclusion

The Committee discussed the Workforce Race Equality Standard and Workforce Disability Equality Standard reports from the previous year and noted the areas of improvement and outstanding work needed. The EDI Action Plan was discussed which shows, at a high level, the priorities for the remainder of 2024/25, acknowledging that some of this work will take considerably longer to address. The key objectives were previously approved at Trust Board:

- Eliminate conditions and environment in which bullying, harassment and physical harassment occurs
- Address progression within the Trust for staff protected under the Equality Act
- Engage with racialised and ethnic minority communities to identify and agree core organisational competencies requiring further development.

The People Committee will receive quarterly updates on these actions.

3. Key challenges now and in the medium term

- 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. Since the last People Committee, Executive Directors have met with the Guardians to explore this further. Further analysis to be undertaken and the NHS Staff Survey 2024 will help inform this work.

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

Turnover

Figures have consistently improved for several months, and the Trust turnover is 9.2% which is the lowest rate for several years.

Exit Questionnaires

The response rate for exit questionnaires has improved to 22.5% (8.4% the previous quarter). Since April, the ESR exit questionnaire has been utilised. The responses can now be better aligned to the NHS People Promise. Exit Interviews are undertaken on request. There will be ongoing communication regarding the Exit Questionnaire as part of the ESR roll out.

Clinical Supervision

The Workforce Performance Report saw a slight improvement in the number of staff with a recorded clinical supervision. However, it was noted that a significant improvement in uptake had occurred since the report had been produced with dashboards that morning indicating compliance well over 70%. Groups were thanked for their continued focus in this area. It was noted that August is often a period where training, clinical supervision and appraisal rates drop slightly due to the holiday period, but this will be monitored.

Training

Since the completion of the training review and introduction of trajectories to give focus to key topic areas there has been significant improvement in these areas.

Equality, Diversity and Inclusion

The Committee was provided with an update in terms of the Workforce Race Equality Standard and Workforce Disability Equality Standard. Some positive progress has been seen, particularly around the numbers of Black, Asian and Minority Ethnic staff who now work for the Trust with these staff totalling 11% of the workforce, an increase from 9.06% last year and 7.5% the previous year. This is largely the result of the significant work which has been undertaken in recent years in respect of inclusive recruitment and the agreement to provide sponsorship to staff when visas expire. The increase in Black, Asian and Minority Ethnic staff is positive progress, however, this tends to be in the lower banded posts and focus over coming years is to improve numbers in higher bandings.

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

No specific actions were noted.

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

There is one key item which will be discussed at a future Trust Board:

Medical Revalidation Report

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 which was discussed in detail at the meeting.

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

The 2024 People Committee Review of Performance against the Terms of Reference was approved at the meeting with an acknowledgement that amendments may be required once the governance around Health Inequalities is agreed.

9. Review of Board Assurance Framework and amendments thereon

At the July 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.

People Committee		
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
August 2024

Lynne Shaw
Executive Director of Workforce and OD

4.2 INTEGRATED PERFORMANCE REPORT ? A GREAT PLACE TO WORK

Lynne Shaw, Executive Director of Workforce and Organisational Development

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

Darren Best, Chair

5.1 RESOURCE AND BUSINESS ASSURANCE COMMITTEE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

5.1 RABAC Committee Assurance Report - Aug 24 DRAFT.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Wednesday 4 September 2024

Name of Board Committee	**Resources and Business Assurance Committee (RBAC)**
Date of Committee meeting held	7 August 2024
Date of next Committee meeting	TBC – under consideration

1. Key areas of Focus

- 24/25 Financial Position
- CEDAR update
- Trust Treasury Policy
- Agency Expenditure and usage
- Utility Report
- PLACE report
- Corporate Benchmarking Return 23/24
- Cost Collection Results 22/23
- Cost collection return 23/24
- Financial Sustainability and underlying position
- Digital Highlight Report
- Digital Maturity Assessment
- Briefing on Global Crowdstrike incident
- Provider collaborative integrated update

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 Financial Position</u>
The committee received the Finance report relating to Month 3. Key risks to the financial position were outlined in the finance report:

Unallocated savings targets. This reduced this month as items were allocated as outlined in the previous months board report. Several avenues are being explored for the remaining value (£3.9m) including retention of Lennox income from NHSE, ICB income and further cost savings from loss making services (Specialist Group)

Inpatients – forecast overspend of c£1.6m – a recovery plan is being developed with the Group and the frequency of well led meetings are being increased to increase support to the Group to deliver.

Corporate savings – shortfall on corporate savings targets is being addressed through peer review of savings schemes in September, underspends in underspent corporate services being held and 'going further' options being explored.

Medium Term Financial Planning
The committee received an update on the underlying position of the Trust and next steps on production of the medium plan (25/26 and beyond) is expected in September.

CEDAR and capital planning
The Committee noted the verbal update on the CEDAR project and the challenges posed from NHP approval processes. The committee noted the wider capital plan risks and the reforecasting exercise currently being undertaken to explore ways of mitigating the current forecast position.

Annual Cost Collection & Corporate Benchmarking
The committee received an update on the submission of cost collection data for 23/24 and noted this was in line with the approved plan for the last committee meeting. It also received the output from the 22/23 cost collection exercise which reported and aggregate index of 112 – implying the Trust is 12% more expensive than average for the sector. The committee noted the data quality issues around inpatients experienced nationally and lack of nuance around specialist services in this benchmarking.

The committee noted corporate benchmarking data was submitted and awaits the output form this exercise.

Digital
The committee received assurances around the delivery of digital projects. It also received an update on the crowdstrike incident including initial learning. The committee received the Digital Maturity Assessment (DMA) and noted the weaknesses identified in the leadership and governance domain. The committee has requested a report to address these weaknesses for consideration which is intended to inform a future full board discussion on this topic.

Commissioning
The committee heard updates on the provider collaborative and lead provider arrangements.

Estates
The committee received an update on utilities and noted the increase in consumption and prices. Electricity and water usage were up whilst gas consumption was down. The Trust continues to work with its energy broker to maximise benefits from the current contracts where possible.

3. Key challenges now and in the medium term

The key challenge faced by the Trust is the development of a medium-term sustainability plan. A planning paper is expected in September to support mitigation of these challenges beyond the current year.

The threat of cyber-attack remains elevated given current geopolitical environment and the increasing reliance on digital technology increases this through time. The committee continues to develop its expertise in this area to provide assurances to the Board of Directors on cyber security. It should be noted that the Trust is DSPT compliant.

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 schemes – particularly in relation to at risk areas such as corporate and containing costs within ward budgets. Well led meetings are increasing in frequency to support improvement in these forecasts.
- 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.

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.

The committee requires increased levels of detail to enhance assurance on the financial position and is considering increasing the frequency of meetings. The finance report is also being reviewed to ensure it focuses clearly on the key risk areas for the Trust from a strategic perspective.

A planning paper will be developed to support planning for 25/26 and beyond. This is due in September.

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. The committee noted that progress in containing the size and cost of the workforce requires increased pace to remain sustainable.

The committee has commissioned a report from the Digital team to consider gaps identified in the Digital Maturity Assessment. This will be escalated to Board of Directors for discussion following review by the committee.

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

The Committee were asked to consider whether the Treasury Policy should continue to come back in future for comment. It agreed it would not and the Treasury policy would be treated like any other policy and did not require explicit oversight of the committee. The committee agreed that a review of the SFIs/ SORAD would take place to ensure governance around any future drawdowns of working capital support can be operationalised sensibly given the changes in frequency of board meetings recently. It is not expected this is an imminent issue, but rather a sensible response to the Board arrangements.

9. Review of Board Assurance Framework and amendments thereon

At the August 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		
• 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 received a recommendation to de-escalate the temporary staffing risk to the directorate risk register and introduce a new BAF risk which concerns affordability of the workforce and the impact of sustainability.

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
August 2024

Kevin Scollay
Executive Director of Finance

5.2 FINANCE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

5.2 Public - M04 Finance Update.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 4th September 2024**
Title of report	**Month 4 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			
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

Wednesday 4th September 2024

Month 4 Finance Report

1. Executive Summary

1.1 **At Month 4 the Trust has generated a £6.3m deficit.**

1.2 This deficit is **ahead of the financial plan at Month 4 by £2.1m**. This is because the Trust has completed a quarterly review of liabilities and released accruals no longer deemed to result in a liability. There are also underspends on some budgets year to date, not expected to be maintained to the year end.

1.3 At the end of Month 4 the Trust has spent £3.5m on agency staff against a plan £3.6m.

1.4 **Expenditure on the Trust capital programme is £1.6m lower than expected** at the end of Month 4. This budget is currently assumed to breakeven by year end due to slippage, but there is a significant risk of overspending by up to £2.4m due to commitments to move services away from the CAV site.

1.5 **The Trust has a cash balance of £30.2m** at the end of Month 4 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 4.

Table 1: Key Financial Metrics

	Month 3		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit)	(£8.4m)	(£6.3m)	(£2.1m)
Agency Spend	£3.6m	£3.5m	(£0.1m)
Cash	£23.4m	£30.2m	(£6.8m)
Capital Spend	£4.6m	£3.0m	£1.6m

3. Financial Performance

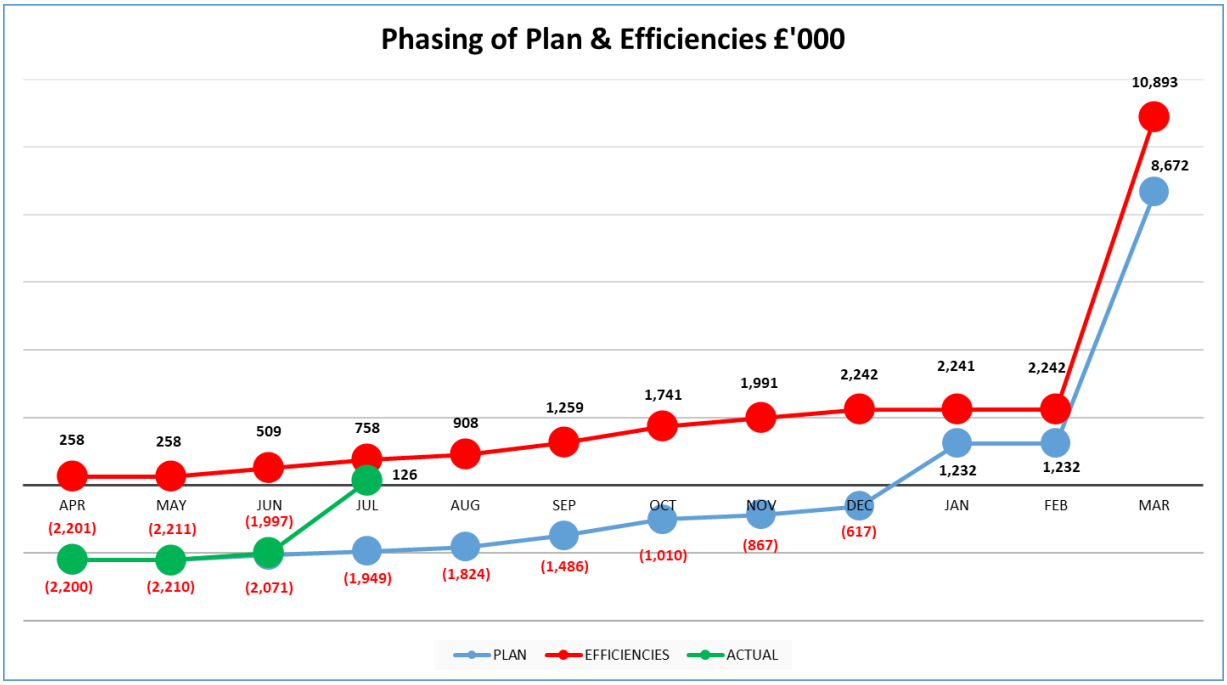
Income and Expenditure

3.1 At the end of Month 4 the Trust has reported a £6.3m deficit on Income and Expenditure, which is better than the plan submitted to NHSE by £2.1m.

3.2 The Trust monthly planned deficit/surplus is shown in the graph below. 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. 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.

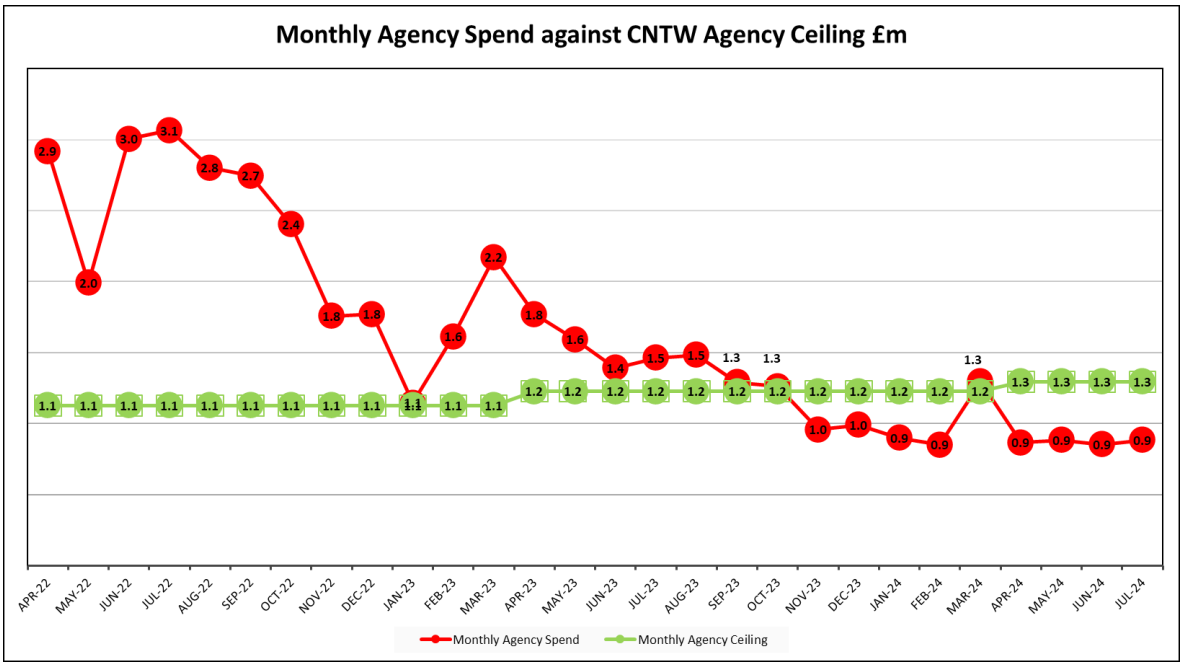
3.3 The trust plan included £6.2m unidentified efficiencies. This has reduced to £3.9m at the end of Month 4 and is expected to fall to £0m in the Month 5 reported position. The Trust will therefore have a de-risked financial plan and will be focusing on managing in year variation and the production of a its medium-term plan from 25/26 and beyond.

Graph 1: Monthly Financial Performance



3.4 Graph 2 below highlights the agency performance from April 22. The Trust has spend £3.5m on agency in to the end of July against a plan of £3.6m. 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: Monthly Agency Performance



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 July against the pre-COVID staffing levels (Dec 19), 24 months ago, 12 months ago, March 24 and last month.

Total wte have reduced from last month by 65, with a reduction in substantive staff of 35 and agency staff of 30 with no change in bank staffing overall. The trust annual workforce plan identifies a reduction of over 450 wte in 24/25.

Table 2: Whole Time Equivilient (WTE) movements

	Dec-19	Mar-24	Apr-24	Jun-24	Jul-24	Change since Dec 19	% Change	Change Since March 24	% Change	Change since last Month
COMMUNITY CARE GROUP	2,491	3,026	3,040	3,017	3,002	510	20%	(24)	-1%	(15)
INPATIENT CARE GROUP	1,538	1,979	1,990	1,991	1,962	425	28%	(16)	-1%	(28)
SPECIALIST CARE GROUP	1,809	1,912	1,920	1,871	1,857	48	3%	(55)	-3%	(15)
LOCALITY BASED MGT	34	50	0	0	0	(34)		(50)		0
CLINICAL SUPPORT	336	479	480	476	473	137	41%	(6)	-1%	(3)
	6,209	7,445	7,430	7,356	7,295	1,086	17%	(150)	-2%	(61)
CORPORATE & OTHER	1,159	1,340	1,335	1,324	1,320	161	14%	(20)	-1%	(4)
	7,367	8,785	8,765	8,680	8,615	1,247	17%	(170)	-2%	(65)

4. Cash

Table 3: Year to Date (YTD) Cash performance

	Year To Date		
	Plan (£m)	Actual (£m)	Variance/ Rating (£m)
Cash	23.4	30.2	(6.8)

4.1 Cash balances at the end of July are higher than planned. The Trust cash balances have reduced by £0.9m since last month.

4.2 The Trust is ahead of plan for I&E and has an underspend on the capital programme which is currently supporting cash balances being better than planned.

5. Capital & Asset Sales

5.1 The Trust capital spend at the end of Month 4 is £1.6m lower than planned.

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

5.4 The Trust is currently reviewing capital forecasts to identify any opportunities to mitigate the £2.4m risk associated with the CAV site move.

Table 4: YTD Capital Position

	Year To Date		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**
Capital Spend	4.6	3.0	(1.6)
Asset Sales	0.0	0.0	(0.0)

6. Recommendations

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

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

Kevin Scollay, Executive Director of Finance

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

Darren Best, Chair

6.1 CHARITABLE FUNDS COMMITTEE

Vikas Kumar, Committee Chair

REFERENCES

Only PDFs are attached

6.1 Charitable Funds Committee Assurance Report September DRAFT.pdf

Board Committee Assurance Report
Meeting of the Board of Directors/Corporate Trustee
Wednesday 4th September 2024

Name of Board Committee	**Charitable Funds Committee**
Date of Committee meeting held	31 July 2024
Agenda items/topics considered	See below
Date of next Committee meeting	30 October 2024

1. Key areas of focus

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. The group are in the process of developing their Terms of Reference. Colleagues from Public Health joined the Chairs meeting where the group discussed how NHS Charities can align with Corporate Social Responsibility and the Community Promise Framework addressing health inequalities.

The Committee are currently exploring options for a Patron for the SHINE Fund.

Time has been allocated at October meeting to explore long-term objectives and how these will align to the Trust's Equality, Diversity and Inclusion and health inequalities strategic ambitions as well as reviewing investment in community services, our fundraising strategy to allocate larger sums of money whilst keeping service users and carers voice at the forefront and will also be working closely with Staff Networks.

The Committee received an update on the expenditure log, and fund balances including the Trust's general 'Shine' Fund. There has been one new fund open in the period relating to the Hadrian Ward at Carleton Clinic. There have been 9 applications to withdraw from specific funds and 10 SHINE fund applications during the period.

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

2.1 Charity accounts update

The Committee received an update on the expenditure log, and fund balances including the Trust's general 'Shine' Fund. There has been one new fund open in the period relating to the Hadrian Ward at Carleton Clinic. There have been 9 applications to withdraw from specific funds and 10 SHINE fund applications during the period.

2.2 Charity resource and support

It should be recognised that the Charity activity, awareness, and fundraising activities has increase significantly 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 work over the last 12 months to raise the profile of the charity has also increased linkages between the charity and other activity / key developments.

NHS Charities Together funding for the Marketing Officer post ended on 31st July 2024 and recognising the ability to deliver on the Charity strategic objectives would be adversely impacted by the loss of the post, the Committee approve the proposal to fund the Marketing Officer post recurrently from the SHINE fund for a further 12 months.

3. Key challenges now and in the medium term

3.1 Funding externally

The key challenge for the Trust Charity is to review potential plans to fund externally as currently SHINE find only supports the Trust's service users and carers. At the October meeting the original trustee document dated 2017 will be reviewed to help understand if the Charity can include funding externally.

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

Time has been allocated at October meeting to explore long-term objectives and how these will align to the Trust's Equality, Diversity and Inclusion and health inequalities strategic ambitions as well as reviewing investment in community services, our fundraising strategy to allocate larger sums of money whilst keeping service users and carers voice at the forefront and will also be working closely with Staff Networks.

4.2 Example of the impact the charity can have…

The Committee received an update of the Cycle Hub at St George's Park who were successful in their bid and now have 10 mountain bikes, 2 smaller bikes, 2 electric bikes and 1 trike. The electric bikes are beneficial for those with additional access needs. Following on from the bikes the site now has a Cycle Hub which is a designated space for our service users to keep active. There are sessions on a Monday and a Friday held by both the Exercise Therapy Team and Occupational Therapists. This involves using the Hub as well as riding on designated cycle routes in the surrounding area. This gives our service users a sense of freedom and change of environment. There are plans to move forward to ride in other areas such as Newcastle. There are hopes to establish a similar set up at St Nicholas Hospital and Hopewood Park. It will also be beneficial for Cumbria to have a Hub and the Exercise Team in Cumbria which is currently being reviewed.

The work over the last 12 months to raise the profile the charity has also increased linkages between the charity and other activity / key developments. This includes the new Woodwork Shop at Sycamore opening 31 August 2024 will donate proceeds to the Shine fund. All self-help guide sales now include a 5% donation to the Shine Fund (we have already confirmed income of £75k in two months from the sale of self-help guides – 5% of which will go to Shine), New Shine visuals across entrances at all Trust sites.
The Charity has also been contacted by two external donors in recent months who wish to leave legacy donations. The value of these is pending.

Future plans for the Charity include:

- Establishment of a Volunteer Fundraising Committee
- Rebuild of a new website/platform.
- Increase charity income through partnerships.

- Exploring how the charity can play a role in supporting our commitment to equality, diversity, and inclusion by engaging communities to tackle mental health stigma and promote mental health wellbeing.
- Exploring how the charity can play a key role in addressing health inequalities and tackling stigma around mental health, learning disabilities and autism.
- Linking in with the Chamber of Commerce to gain support and raise the profile of mental health charity giving within the private sector.
- Meetings with Amazon via Amazon attendance at employee events
- New fundraising opportunity for staff contributions (Pennies from Heaven).

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.

Vikas Kumar **Charitable Funds Chair**	Debbie Henderson **Director of Communications and Corporate Affairs**	Kevin Scollay **Executive Director of Finance**

September 2024

7. GOVERNANCE AND REGULATORY

7.1 AUDIT COMMITTEE ASSURANCE REPORT

David Arthur, Committee Chair

REFERENCES

Only PDFs are attached

7.1 Audit Committee Assurance Report - Aug 24 DRAFT v2.pdf

Board Committee Assurance Report
Meeting of the Board of Directors
Wednesday 4 September 2024

Name of Board Committee	**Audit Committee**
Date of Committee meeting held	Wednesday 7 August 2024
Agenda items/topics considered	See Section 1
Date of next Committee meeting	Wednesday 6 November 2024

1. Key areas of focus

- Update on Duty of Candour Training progress (deferred)
- Update on Long term segregation and prolonged seclusion progress (deferred)
- Onboarding process update
- Committee assurance update – RABAC
- CQC visits (deferred)
- CQC unannounced (visit 16th July) update (deferred)
- BAF Update
- Mazars terms and conditions update
- NTWS engagement letter
- Internal Audit Progress Report (including outstanding actions exception report)
- Local Counter Fraud Progress Report

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

2.1 Duty of Candour and Long-Term Segregation updates

The Director of Nursing, Therapies and Quality Assurance was due to present and update on the progress made in these areas but was unable to due to involvement with the organisational response to potential public disorder in Newcastle on the day of the committee. This item was therefore deferred.

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 within this audit. The committee received assurance that all actions highlighted in the audit have now been completed. A new process has been introduced that supports managers to conduct ID checks on the first day of work and a DPIA has ben conducted which supports this process from an Information Governance perspective. The Integrated Performance Report now includes a quarterly update on local induction compliance quarterly. A follow up audit has been added to the list of prospective audits to ensure changes have been effective.

2.3 Limited assurance internal audit report on Mental Health Act – s136 Place of Safety

The committee received the internal audit update which included a limited assurance report which reviewed compliance with the PGN which covers compliance with s136 of the Mental Health Act. The audit also reviewed record keeping and adherence to timescales included within the PGN. The report identified a number of instances of incomplete and inconsistent record keeping which undermine the ability to demonstrate compliance with the PGN and the MHA.

2.4 Outstanding Audit Recommendations

The committee were presented with a report which highlighted that the number of audit recommendations that have no current update has increased over the last 12 months. The number of recommendations without current updates has increased to 45 in the August 24 report. Audit One briefed the committee that since the report was prepared this number had fallen to 18 following a series of reminders issued by the Director of Finance to relevant managers.

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 BAF identifies 3 key strategic risks for the organisation:

- 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.
- The ability of the Trust to meet its regulatory standards in relation to access, responsiveness and performance, resulting in a risk to the quality and safety of services.
- Failure to develop a sustainable workforce model to recruit/retain and support a workforce which meets the strategic aims of the organisation.

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

4.1 Internal Audit progress update

The Internal Audit report provided detail on five final reports issued during the period. Delivery of the 24/25 plan remains on track and has accelerated over the last quarter.

These reports were:

- Mental Health Act: s136 A place of Safety - LIMTED ASSURANCE
- Allocate: North Cumbria - REASONABLE ASSURANCE
- Bank and Agency – Pre-employment Screening and Onboarding - GOOD ASSURANCE
- Benchmarking of recommendations – BENCHMARKING REPORT
- Medical Job Planning Policy – BENCHMARKING REPORT

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.

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

- Bring back assurances for those updates that were deferred
- Escalate the issue identified in relation to Audit Recommendations with no current update to Board of Directors and Executive Directors should ensure teams are engaging appropriately to reduce this number.

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 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

Paula Breen attended the meeting as Chair of the Resources and Business Assurance 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: • 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.		

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		
• 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 Resource and Business Assurance Committee regarding the ongoing appropriateness of the risks, risk descriptors, mitigations, and actions with the recommendation that that the agency BAF risk is de-escalated to the directorate risk register and new risk introduced regarding affordability of the workforce, which the committee supported.

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.

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 8 to de-escalate the agency risk from the BAF, downgrading to the directorate risk register and instead introduce a new risk in connection to the affordability of the size of the workforce.

David Arthur
Audit Committee Chair
Date: August 2024

7.2 BOARD ASSURANCE FRAMEWORK / CORPORATE RISK REGISTER REPORT

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

7.2a BAF-CRR Risk report August 2024.pdf

7.2b Appendix 1 - BAF Register.PDF

Name of meeting	Board of Directors
Date of Meeting	4 September 2024
Title of report	Board Assurance Framework/Corporate Risk Register Update 2024/25
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 2, 3 and 4 of the report provides an update on the development of the newly added Corporate Risks, BAF strategic risks and where these align (where appropriate), and detail of corporate risks not currently aligned to BAF risks, but which remain a significant area of concern operationally.

2.1. Risks added to the Corporate Risk Register since the August Audit Committee

Note: the Corporate Risk Register is a live document to report risks in real time, reflecting risks escalated, de-escalated and added. These reflect ongoing discussions held at Executive Management Group, Business Delivery Group-Risk meetings and within care groups. Changes to the CRR since the meeting of the Audit Committee held 7 August are provided below with further detail provided in the remainder of the report. Six of the eight new risks added to the CRR relate to waiting times, access/demand and crisis services.

Risk No	Risk description
1822	Significant waiting times (5years +) for both assessment and treatment within the NRGDS pathway. Risk of service user mental health deteriorating whilst awaiting assessment and treatment. Due to waiting times continuing to increase to 6 year wait. There is a greater risk to patients mental health deteriorating and having a negative effect on CNTW reputation.
2329	Crisis team operating below minimum identified safe staffing levels which leads to some patient contacts being cancelled/rearranged/delayed. The service provision is significantly impacted by the crisis team staffing the 136 suite. This frequently takes two staff members away from other duties for the entirety of their shift leading to delays in responding to assessment and triage referrals and cancellation of home visits. This is almost likely to happen and would have a significant impact on service provision and safety if it were to happen.
2520	Demand has outstripped capacity from commissioned resources within ADHD pathway. Priority has been given to the treatment team and as a result the number of assessments completed is reduced. An increase in the number of referrals has resulted in a substantial waiting list. This list poses a risk to the service as the team are unable to monitor the waiting list for any risk concerns which may lead to patient safety incidents.
2796	Crisis teams need to be available to support staffing into the 136 suite, therefore, when

	someone is detained to a suite, there is a risk of depleting the capacity of the crisis assessment and home based treatment teams. This may result in prolonged response times to those who are in a mental health crisis and those who are in a home treatment pathway. This is likely to happen and could result in major harm to patients/others within the CRHT pathways.
2823	A role of the Crisis Team is to support services users who have been placed on a 136 and have been brought to HWP 136 suite (as a place of safety). When a service user arrives (with police) - a joint risk assessment is completed (between police and Crisis clinician) to assess whether police need to remain to support due to level of risk. If risks assessed as reduced, police can handover responsibility to crisis team to manage and leave the suite. Due to factors related to RCRP (including police declining to return when requested due to increase risks), the 136 environments, delays in MHA or bed allocation and the unpredictability of services users presentation - in terms of both mental state and risks. These 4 factors can lead to services users presenting with increased levels of violence and aggression to be managed by clinicians who have limited options to try and deescalate the situation within an enclosed environment. At these times there is potential of increase level of verbal abuse, aggression and violence towards staff. These all have a significant impact on staff well-being and safety. Service user well -being and safety could also be impacted - especially at the times when detained in the suite for a lengthy period of time. There is also the impact on staffing levels for other parts of the crisis service - when there is an increase demand in the 136 suites been in use. This has an impact on rest of the team in terms of an increase workload but also can reduce the team's response to all other services users, which could impact their care and treatment.
2903	Newcastle and Gateshead CYPs average waiting times for specialist neurodevelopmental assessment review is approximately 36 months. It is expected that demand for diagnosis will continue. This may result in the needs of the Children and Young People not being met, delay them accessing appropriate support and potentially cause significant harm. This could also result in complaints for the service.
2489	Due to no stocks of medication for service users to utilise for symptoms of ADHD this may result in unmediated patients, deterioration of mental health, suicidal thoughts, loss of employment, increase of complaints into the service causing staff to become stressed and increase workload due increase contacts from service users re medication updates. This is likely to happen with a major impact on services and service users.
2508	Due to a number of GP surgeries handing back medication management to community teams there is a risk that patients will not receive timely prescriptions or physical health monitoring which may lead to harm to patients or their carers.

2.2. Highest level BAF risks

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: • 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.

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.

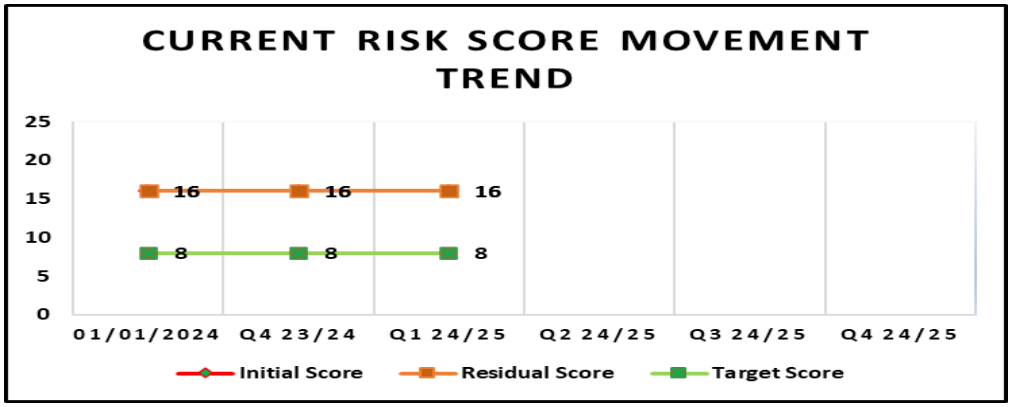
People Committee		
BAF Risk 2542	**Residual Score 16**	
Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	**Likelihood**	**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 culturally diverse 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 (BAF) risks as of 1 August 2024

3.1 BAF risks aligned to the Quality and Performance Committee as of 1 August 2024

Date Opened	**01/01/2024**	**Risks Ref No:**	**2510**	**Version**	**3**	**Risk Appetite/Subcategory**	**Quality Safety -** CNTW has a **LOW** appetite for risks that may compromise safety. (6-10) - **Standards**
Review Date	**30/09/2024**						
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 CYPS neuro. Most individuals receiving care from CNTW are open to community services only, be that crisis teams or CTT's. For a small number of service users their clinical presentation is such that they require inpatient care to augment their treatment. The ability to access beds in a timely fashion has a significant impact from an individual, family, Trust, and system perspective. Any shortfalls or deficiencies in community provision may adversely impact on the number of people requiring a period of inpatient care. Gaps in Controls/Assurances. • 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.							
	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 in Q1?	**Description**		**No**		
	Owner		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**No**		
	Actions Completed & Closed		**Yes 14679 has been closed**		**28.06.24**
	New Actions Added		**Yes 15204 & 15246 have been added**		**28.06.24**
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; Trusted Assessment.	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.
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	Feedback/notes from this meeting.

admission.	
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	**30.11.24**
13083	Continue to work with commissioner colleagues to obtain years 3 ARRS funding - Throughout 24/25	Regular meeting established for ARRS workers.	Russell Patton	**30.11.24**
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	It was discussed at access oversight group end of June and each place in community care group is to provide an update report on current processes in place.	Andy Airy	**30.09.24**
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	**30.09.24**
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	**30.09.24**
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	**30.11.24**
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	**30.09.24**
14678	Successfully transition away from CPA – **during 2024/25**	Review outputs from pioneering teams to inform keyworker and MDT requirements.	Rajesh Nadkarni.	**30.09.24**
14679	Successfully implement 111 service delivery model to support the inpatient pathway – **Q1 24/25**	This action has been completed and closed.	Ramona Duguid	**Closed 28.06.24**
15204	ADHD adult pathway recovery plan required with system partners.	ADHD waiting times report for adults escalated to ICB for agreement on way forward. Exception report provided to EMG and Q&P. Impact and agreement from ICB to be reviewed September 2024.	Ramona Duguid	**30.09.24**
15246	CA-23-107 Sexual Safety clinical audit dated 14.06.24. Area of concern – Governance, risk	Several actions to be completed including Improvement in reporting of sexual incidents	Tracy Kerry	**31.12.24**

	management and control arrangements provided limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required. As per policy the risk rating shows **high** so the re-audit is due in Q3 24/25.	and responsiveness; assurance all staff have awareness of Talk 1st strategies and positive impact on patient care; Ward Staff to be trained in the following: Induction, Trauma Awareness, Hate Crime, Raising Concerns, LD/Autism.		

Internal Audit 2024/2025					
Quality & Performance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
No Internal audits aligned to this risk in Q1					

Clinical Audit 2024/2025					
Quality & Performance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
CA-23-107 Sexual Safety clinical audit	*				**BAF 2510 SA1**

Corporate Risk Register risks aligned to the Quality and Performance Committee BAF risks

Corporate Risk Register - 2463 Aligned to BAF Risk 2510		
Corporate Risk register 16+ Risk 2463	**Residual Score 16**	
The geographical isolation of Yewdale ward from other elements of the urgent care pathway is such that we need to ensure that this "stand alone" facility is staffed in such a way that the workforce and MDT have appropriate skills, competencies and head count to support the provision of high quality, sustainable care.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in Controls		
• The long term viability of Yewdale ward as an inpatient clinical facility is under review by the Trust and the ICB. Opportunities for alternative pathway provision in West Cumbria are being considered which would enable a re-provision of beds based services to Carlton Clinic. • To ensure suitable MDT input at the most significant time in an inpatients journey it has been agreed that admissions will not take place out of hours to ensure appropriate clinical cover is available. This will be kept under regular review to ensure that there are no adverse issues from a patient and service perspective.		

Corporate Risk Register - 1822 Aligned to BAF Risk 2510		
Corporate Risk register 16+ Risk 1822	**Residual Score 16**	
Significant waiting times (5years +) for both assessment and treatment within the NRGDS pathway. Risk of service user mental health deteriorating whilst awaiting assessment and treatment. Due to waiting times continuing to increase to 6 year wait. There is a greater risk to patients mental health deteriorating and having a negative effect on CNTW reputation.	**Likelihood** **4. Likely**	**Impact** **5. Major**
Gaps in Controls		
• To implement and embed the recovery plan within NRGDS to work towards achieving SMART actions within required time frames.		

Corporate Risk Register - 2903 Aligned to BAF Risk 2510		
Corporate Risk register 16+ Risk 2903	**Residual Score 16**	
Newcastle and Gateshead CYPs average waiting times for specialist Neurodevelopmental assessment review is approx. 36 months. It is expected that demand for diagnosis will continue. This may result in the needs of the Children and Young People not being met, delay them accessing appropriate support and potentially cause significant harm. This could also result in complaints for the service.	**Likelihood** **4. Likely**	**Impact** **5. Major**
Gaps in Controls		
• Transformation work to look at existing waiters and the support they require • Newcastle and Gateshead Place working with colleagues to develop multi-agency engagement events to support young people and families who have been referred for neuro assessment. Also contributing to family hubs to ensure needs are met by most appropriate agency. • Supporting with the ICB led transformation work to reduce longest waiters across the region - 4 main work streams including workforce mapping, data collection, digital offer and virtual MDT. • Team wide audit led by leadership team to review both quality of documentation, treatment plans and discharge to ensure appropriate flow. • Working towards targeted first appt reducing the wait to help starting.		

Corporate Risk Register – 2329 Aligned to BAF risk 2510		
Ward/Department Risk 2329	**Residual Score 16**	
Crisis team operating below minimum identified safe staffing levels which leads to some patient contacts being cancelled/rearranged/delayed. The service provision is significantly impacted by the crisis team staffing the 136 suite. This frequently takes two staff members away from other duties for the entirety of their shift leading to delays in responding to assessment and triage referrals and cancellation of home visits. This is almost likely to happen and would have a significant impact on service provision and safety if it were to happen.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
• Risk to be discussed at EMG in relation to possible escalation to CRR in line with risks 2796 and 2823 also.		

Corporate Risk Register - 2481

Aligned to BAF risk 2510		
Ward/Department Risk 2481	**Residual Score 16**	
Due to the financial loss from 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 at risk of not receiving appropriate care, and their treatment being delayed. This could have major detrimental impact on patients' mental health which may also result in Trust reputational damage.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in Controls		
• Executive Director of Finance ongoing meetings with ICB Director if Finance to agree a resolution. • To complete a review of the Clinical Model including the financial impact.		

Corporate Risk Register - 2520 Aligned to BAF risk 2510		
Ward/Department Risk 2520	**Residual Score 16**	
Demand has outstripped capacity from commissioned resources within ADHD pathway. Priority has been given to the treatment team and as a result the number of assessments completed is reduced. An increase in the number of referrals has resulted in a substantial waiting list. This list poses a risk to the service as the team are unable to monitor the waiting list for any risk concerns which may lead to patient safety incidents.	**Likelihood**	**Impact**
	4. Likely	**5. Major**
Gaps in Controls		
• Development of Welcome Group at point of acceptance for Assessment initially starting in September. • Clinical Manager to have discussion with Associate Director regarding admin resource required to support Welcome Group. • Ongoing liaison with Group Directors in relation to potential "pull back" of GP activity which may in turn put pressure on this team and increase risk further.		

Corporate Risk Register - 2770 Aligned to BAF risk 2510		
Ward/Department Risk 2770	**Residual Score 16**	
Due to lack of clinical space following urgent need to close 11/12 Portland Square, there is a risk that the CTT service will not be able to see the same volume of patients as normal. This could lead to increased waiting lists and impact ability to keep some patients safe. This risk is likely to happen with significant impact if it were to happen. In addition, CTT East staff are currently dispersed across multiple sites. This will have an impact on the effectiveness of the team.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in Controls		
Review controls associated with this risk when patient facing service moves to 4 Wavell Drive. Although this will allow accommodate a number of taff within the service, there will still be a requirement to secure longer term space for other functions.		

Corporate Risk Register - 2796 Aligned to BAF risk 2510		
Ward/Department Risk 2796	**Residual Score 16**	
Crisis teams need to be available to support staffing into the 136 suite, therefore, when someone is detained to a suite, there is a risk of depleting the capacity of the crisis assessment and home based treatment teams. This may result in prolonged response times to those who are in a mental health crisis and those who are in a home treatment pathway. This is likely to happen and could result in major harm to patients/others within the CRHT pathways.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
Ongoing Trustwide review lead by Chole Mann, around functions of Crisis Team, and impact / most appropriate service model to support 136 suites Trustwide.		

Corporate Risk Register Aligned to BAF risk 2510		
Ward/Department Risk 2823	**Residual Score 16**	
A role of the Crisis Team is to support services users who have been placed on a 136 and have been brought to HWP 136 suite (as a place of safety). When a service user arrives (with police) - a joint risk assessment is completed (between police and Crisis clinician) to assess whether police need to remain to support due to level of risk. If risks assessed as reduced, police can handover responsibility to crisis team to manage and leave the suite. Due to factors related to RCRP (including police declining to return when requested due to increase risks), the 136 environment, delays in MHA or bed allocation and the unpredictability of services users presentation - in terms of both mental state and risks. These 4 factors can lead to services users presenting with increased levels of violence and aggression to be managed by clinicians who have limited options to try and deescalate the situation within an enclosed environment. At these times there is potential of increase level of verbal abuse, aggression and violence towards staff. These all have a significant impact on staff well-being and safety. Service user well -being and safety could also be impacted - especially at the times when detained in the suite for a lengthy period of time. There is also the impact on staffing levels for other parts of the crisis service - when there is an increase demand in the 136 suite been in use. This has an impact on rest of the team in in terms of an increase workload but also can reduce the team's response to all other services users, which could impact their care and treatment.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
• Bespoke sessions for crisis ream re management of S136 including reasonable force and incident to support immediate safety of staff and service users when managing violence and aggression • Discuss potential changes to PMVA training include the role of the response team when responding to an incident at the 136 suite • Explore the use of Radios to support communication to others at team base. • Explore CCTV options within 136 area and access/viewing footage for Band 7 and above members of the team • View of policy guidance to include OOH access to medication for services users within 136 from wards instead of community base pharmacy		

Date Opened	**01/01/2024**	**Risks Ref No:**	**2511**	**Version**	**3**	**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	**30/09/2024**						
Executive Lead	**Sarah Rushbrooke**	**Lead Committee**	**Quality & Performance**			**Strategic Ambition**	**SA 1 - Quality care, every day**

Risk Description

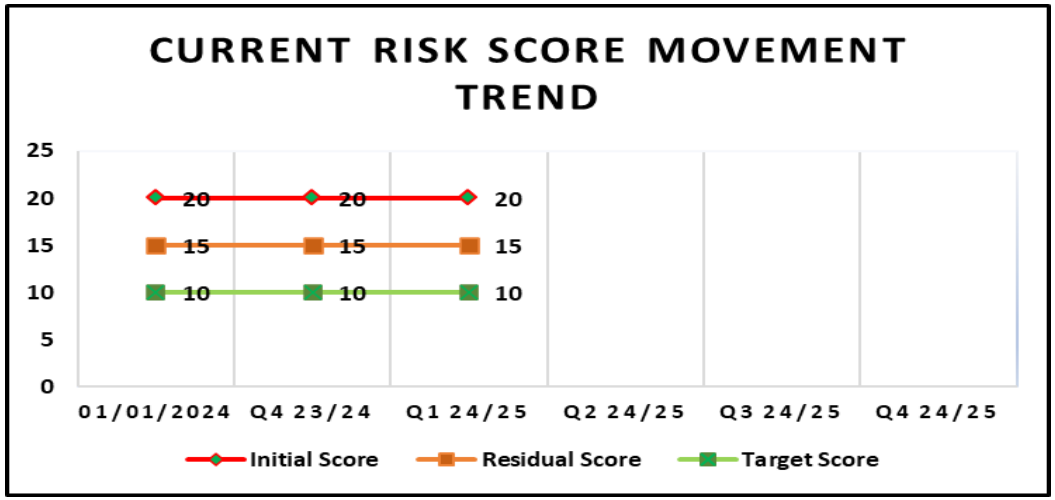
Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.

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	Score Residual Risk Score Movement Chart
Initial Score	4. Likely	5. Major	**20**	
Residual Score	3. Possible	5. Major	**15**	
Target Score	2. Unlikely	5. Major	**10**	



Key questions:	Summary of findings				Updated
Have there been any changes to risk in Q1?	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 CNTW 23-24 07 Performance Management & Reporting Internal Audit final report.		28.06.24
	Actions Completed & Closed		Yes action 13095 & 15248 have been closed		28.06.24
	New Actions Added		Yes action 15182; 15249 & 15254 have been added		28.06.24
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	Feedback / updates on areas of improvement and good practice at CQC

and action plans.	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.
CNTW 23-24 07 Performance Management & Reporting (15.04.24) The audit involved the review and testing of controls associated with the following indicators, mapping controls to one or more of the six dimensions of quality - accuracy, validity, reliability, timeliness, relevance, and completeness.	Final Internal Audit report date 15 April 2024 provides a substantial level of assurance relating to a review of the Trust's processes and controls for Performance Management & Reporting.

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	Formal meetings continue to take place bi-monthly.	**Vicky Wilkie**	**30.09.24**
13095	Sharing of good practice and areas of improvement - ongoing throughout 2023/24	This action has been completed and closed	**Sarah Rushbrooke**	**Closed 28.06.24**
13096	Quarterly updates to Board on progress against closure of action plans - ongoing throughout 2024/25	Quarterly updates continue. Progress update on all remaining Must Do action plans presented to EMG on 24/06/24. Recommendations for making changes to clinical supervision policy/recording system and recommendations for additional	**Sarah Rushbrooke**	**30.09.24**

		processes and quality improvements taken to BDG-Workforce on 14/05/24 and 11/06/24. Paper taken to EMG on 24/06/24 regarding proposed improvement work to enable closure of clinical supervision Must Do action plans. 6 Must Do action plans are on track to close by Q2 2024/25.		
13097	Updates on building works to CQC - ongoing throughout 2023/24	One Must Do action plan linked to environmental shortfalls closed in Q4 2023/24. 2 remain open linked to the CEDAR project and improvements in North Cumbria, 1 on track to close during Q2 2024/25. The environmental shortfalls identified at the Campus for Ageing and Vitality will close once services have transferred to St Nicholas Hospital.	**Vicky Wilkie**	**30.04.25**
13098	Delivery of CQC 'every day is a quality day' preparedness programme - Q3/Q4 2023/24	Programme of communications linked to CQC Must Dos and new CQC Quality Statements has been developed.	**Vicky Wilkie**	**30.09.24**
15182	CA-23-012.02 Nutrition Policy Audit 14/06/2024 - Minor areas of concerns – Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows **high** so the re-audit is due in Q3 24/25.	Several actions to be completed including training being delivered to ward based staff; bespoke training to be offered to specific wards where screening levels are low; introduction of Nutrition screening for under 18's; Dietitians to be trained to write and input into care plans when making dietetic treatment plans on wards.	**Gillian Senior**	**31.03.25**
15248	CA-23-028.01 Physical Health Monitoring compliance with CNTW(C) 29 -19.04.24 – Minor areas of concerns - Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per	Several actions to be completed including review of physical health champion's role and function on all wards; ensure physical health NEWS2 prompt is on the Trust Wide standardised daily review proforma; all staff to complete Physical Health training; CA-23-028.01 action plan has now been completed and has been closed.	**Marie Smith**	**Closed 28.06.24**

	policy the risk rating shows **moderate** so the re-audit is due in Q1 25/26.			
15254	CA-23-035.01 CYPS CPA Care and Treatment Audit 12.04.24 – Moderate areas of concern – Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows **moderate** so the re-audit is due in Q1 25/26.	Several actions to be completed including caseloads to be audited quarterly by clinical leads; Getting to Know You documents to be added to rolling training programme and reviewed monthly as part of caseload management; all staff to complete Safeguard level 3 training; specific child to parent violence training to be provided from safeguard team	**Daisy Mbwanda**	**30.09.24**
15249	CA-23-091.01: Clinical Supervision 10.05.24 - Minor areas of concern – Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows **moderate** so the re-audit is due in Q2 25/26.	Several actions to be completed including increase awareness of compliance levels, relevance of standards to clinical practice and staff wellbeing; policy wording to be reviewed to make requirements clearer; liaise with IT to resolve unknown data quality issues; liaise with Commissioning Quality & Assurance regarding collating safeguarding data, reporting requirements and monitoring responsibilities; all CBUs to be reminded of the clinical supervision training guidance for non-registered staff to ensure local arrangements are in place.	**Esther Cohen-Tovee**	**30.09.24**

Internal Audit 2024/2025

Quality & Performance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
CNTW 23-24 07 Performance Management & Reporting	*				**BAF 2511 SA1**

Clinical Audit 2024/2025

Quality & Performance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**

CA-23-012.02 Nutrition Policy Audit	*				**BAF 2511 SA1**
CA-23-028.01 Physical Health Monitoring compliance with CNTW(C) 29	*				**BAF 2511 SA1**
CA-23-035.01 CYPS CPA Care and Treatment	*				**BAF 2511 SA1**
CA-23-091.01: Clinical Supervision	*				**BAF 2511 SA1**

Date Opened	**01/01/2024**	**Risks Ref No:**	**2512**	**Version**	**3**	**Risk Appetite/Subcategory**	**Quality Safety -** CNTW has a **LOW** appetite for risks that may compromise safety (6-10) – **Patient Safety**
Next Review	**30/09/2024**						
Executive Lead	**Rajesh Nadkarni**	**Lead Committee**	**Quality & Performance**			**Strategic Ambition**	**SA 1 - Quality care, every day**

Risk Description

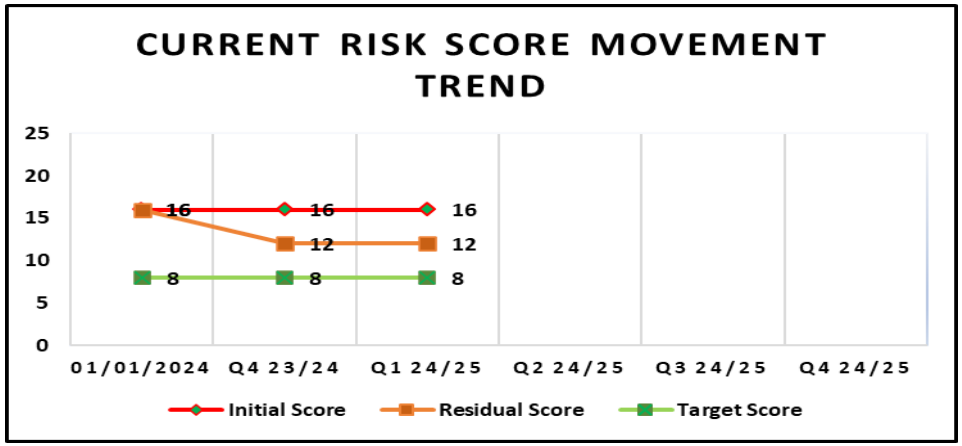
Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern.

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 in Q1?	**Description**		**No**		
	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 1 control wording reviewed and changed**		**28.06.24**
	Actions Completed & Closed		**Yes action 13115 has been closed**		**28.06.24**
	New Actions Added		**Yes actions 15255 & 15256 have been added**		**28.06.24**
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)**
Trustwide Safety and it's subgroup the Patient Safety Learning and Improvement Panel (PSLIP) has oversight of PSIRF implementation and learning from incidents	Regular updates on PSIRF implementation and PSLIP outputs
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 over time rather than a single document.	A plan is in place to undertake a review of a selection of ELRs and AARs to provide assurance on the quality and that learning is being highlighted. Discussions held with new groups to understand how learning is identified through reviews and disseminated to relevant staff.	**Claire Thomas**	**30.09.24**
13115	Training of staff in new investigation methods and engagement - to start in Nov 23 with planned trajectories.	Over 600 staff have been trained since January 24 in the new systems based approaches and completion of the new ELR and AAR templates. - action can now be closed	**Claire Thomas**	**30.06.24 Closed**
14332	Trust Leadership Forum session planned to take place in June 2024 to discuss organisational culture including sessions on just / learning culture.	This session will now be held in July 2024	**Claire Thomas**	**30.09.24**
15255	CA-23-091.01: Clinical Supervision 10.05.24 - Minor areas of concern – Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows **moderate** so the re-audit is due in Q2 25/26.	Several actions to be completed including increase awareness of compliance levels, relevance of standards to clinical practice and staff wellbeing; policy wording to be reviewed to make requirements clearer; liaise with IT to resolve unknown data quality issues; liaise with Commissioning Quality & Assurance regarding collating safeguarding data, reporting requirements and monitoring responsibilities; all CBUs to be reminded of the clinical supervision training guidance for non-registered staff to ensure local arrangements are in place.	**Esther Cohen-Tovee**	**30.09.24**
15256	CA-23-107 Sexual Safety clinical audit dated 14.06.24. Area of concern – Governance, risk management and control arrangements provided limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required. As per policy the risk rating shows **high** so	Several actions to be completed including Improvement in reporting of sexual incidents and responsiveness; assurance all staff have awareness of Talk 1st strategies and positive impact on patient care; Ward Staff to be trained in the following: Induction, Trauma Awareness, Hate Crime, Raising Concerns, LD/Autism.	**Tracy Kerry**	**31.12.24**

	the re-audit is due in Q3 24/25.			

Internal Audit 2024/2025					
Quality & Performance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q1					

Clinical Audit 2024/2025					
Quality & Performance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
CA-23-091.01: Clinical Supervision	*				**BAF 2512 SA1**
CA-23-107 Sexual Safety	*				**BAF 2512 SA1**

Date Opened	**01/01/2024**	**Risks Ref No:**	**2543**	**Version**	**3**	**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	**30/09/2024**						

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.

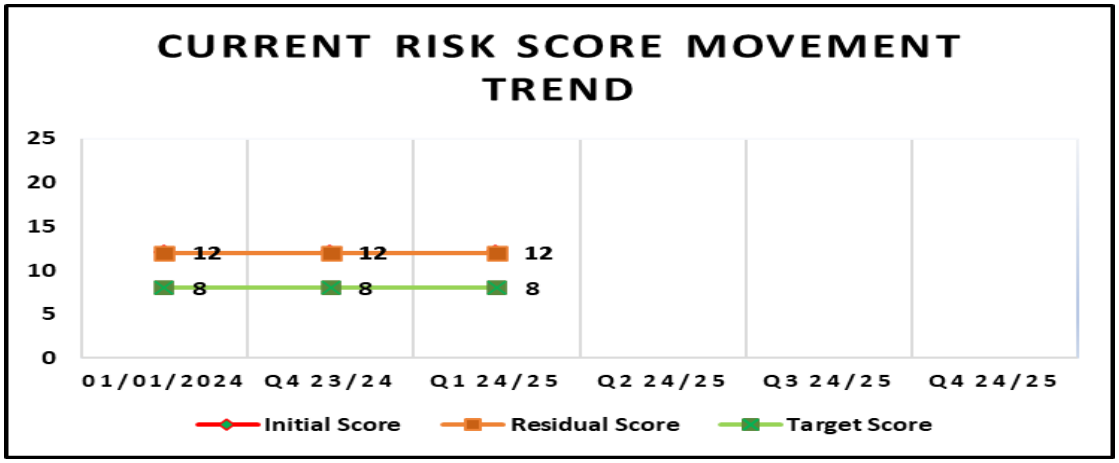
There is a risk that the ability to deliver the transformations required across the Trust affects the quality of services provided and sustainability of services.

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.
Primary care shared care position and GP IA.

	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 in Q1?	**Description**		**No**		
	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 1 control removed**		**28.06.24**
	Actions Completed & Closed		**Yes actions 14688; 14689 & 14690 have been completed**		**28.06.24**
	New Actions Added		**Yes actions 15205 & 15257 have been added**		**28.06.24**
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.
Alignment of Trust priorities for delivery with the NENC ICB transformation agenda for MH&LDA.	MHLDA Board established with shared agenda on national policy requirements and interface with the transformational programmes of work.
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.	We have influenced the ICB on the priorities this action can now be closed.	**Ramona Duguid**	**30.06.24 Closed**
14689	Chief Executive review of the system forum to support the transforming care programmes of work in place with the ICB.	This action is now completed and can be closed	**James Duncan**	**31.05.24 Closed**
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 Completed and closed	**Ramona Duguid**	**31.05.24 Closed**
15205	GP shared Care situation formally escalated to ICB. Internal EPRR approach for potential GP industrial action to be considered.	ICB feedback on shared care awaited. Trust internal meeting to take place in July on GP IA implications.	**Ramona Duguid**	**30.09.24**
15257	CA-23-035.01 CYPS CPA Care and Treatment Audit 12.04.24 – Moderate areas of concern – Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control	Several actions to be completed including caseloads to be audited quarterly by clinical leads; Getting to Know You documents to be added to rolling training programme and reviewed monthly as part of caseload	**Daisy Mbwanda**	**30.09.24**

	framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows **moderate** so the re-audit is due in Q1 25/26.	management; all staff to complete Safeguard level 3 training; specific child to parent violence training to be provided from safeguard team		

Internal Audit 2024/2025					
Quality & Performance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q1					

Clinical Audit 2024/2025					
Quality & Performance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
CA-23-035.01 CYPS CPA Care and Treatment	*				**BAF 2543 SA2**

Corporate Risk Register risks alignment to the Quality and Performance Committee BAF risks

Corporate Risk Register - 2508 Aligned to BAF Risk 2512		
Corporate Risk register 16+ Risk 2208	**Residual Score 16**	
Due to a number of GP surgeries handing back medication management to Community teams there is a risk that patients will not receive timely prescriptions or physical health monitoring which may lead to harm to patients or their carers.	**Likelihood**	**Impact**
	5. Almost Certain	**4. Significant**
Gaps in Controls		
• Rajesh Nadkarni to escalate the issue around shared care arrangements with Neil O'Brien ICB.		

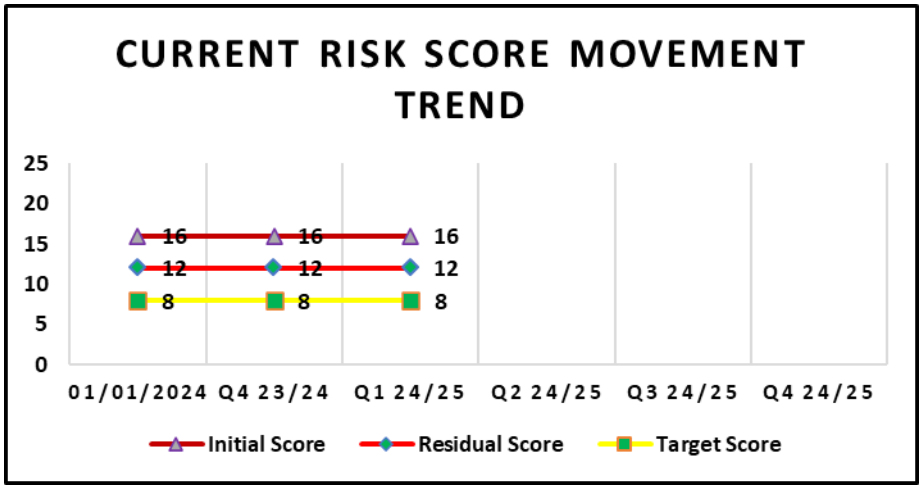
Corporate Risk Register - 2817 Aligned to BAF Risk 2512		
Corporate Risk register 16+ Risk 2817	**Residual Score 16**	
Due to a number of GP surgeries handing back medication management to Community Teams impacting on increased caseloads within Children and Young People's services, there is a risk that patients will not receive timely prescriptions or physical health monitoring which may lead to harm to patients or their carers.	**Likelihood**	**Impact**
	5. Almost Certain	**4. Significant**
Gaps in Controls		
• Rajesh Nadkarni to escalate the issue around shared care arrangements with Neil O'Brien ICB.		

3.2 BAF risks aligned to Resource and Business Assurance Committee as of 1 August 2024

Date Opened	**01/01/2024**	**Risks Ref No:**	**2540**	**Version**	**3**	**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	**30/09/2024**						
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 -** Request for risk to be **de-escalated to Directorate/Group level** to be approved at Board meeting on 04.09.24		**10.07.24**
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)**
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
14325	Enhance monitoring of price cap breaches to support development of action plans to eliminate price cap breaches		**Christopher Cressey**	**31.10.24**

Internal Audit 2024/2025					
Resource and Business Assurance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q1					

Clinical Audit 2024/2025					
Resource and Business Assurance Committee	**2023/2024**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q1					

Recommendation to the Board for approval:

The Resource and Business Assurance Committee received a recommendation to de-escalate the temporary staffing risk to the directorate risk register and introduce a new BAF risk which concerns affordability of the workforce and the impact of sustainability.

Date Opened	**01/01/2024**	**Risks Ref No:**	**2545 Risk 8**	**Version**	**3**	**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	**30/09/2024**						
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

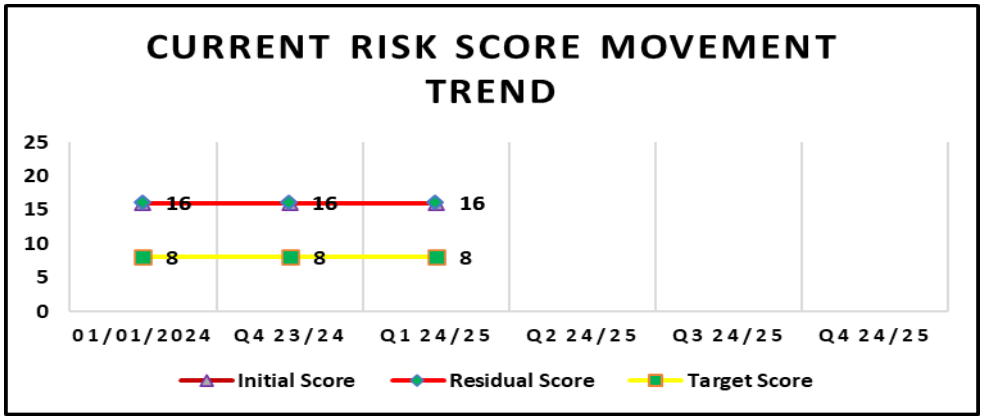
The Trusts is currently operating with an underlying financial deficit and has included assumptions within its current year financial position to eliminate the deficit which were unidentified at the start of the financial year. The Trust continues to operate within a challenging and uncertain financial 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: -

- 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.**		**No**		
	Actions Completed & Closed		**No**		
	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)**
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 escalation meetings.	Minutes from this meeting will be available
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
14326	Medium term financial recovery trajectories to be agreed to support medium term financial planning.		**Chris Cressey**	**30.09.24**
14327	Additional efficiencies to be identified to remove the £6.2m unallocated efficiencies included in the financial plan.	Paper to board in July 24 outlined proposal to mitigate £6.2m residual efficiency reduced risk associated with the 24/25 financial plan.	**Chris Cressey**	**30.09.24**
14328	Extend existing Financial Delivery Plan by extending the planning horizon by 2 years and enhancing reporting on efficiency delivery.		**Chris Cressey**	**30.09.24**

Internal Audit 2024/2025					
Resource and Business Assurance Committee	**2025/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q1					

Clinical Audit 2024/2025					
Resource and Business Assurance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q1					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2546**	**Version**	**3**	**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	**30/09/2024**						
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**	CURRENT RISK SCORE MOVEMENT TREND
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)
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	
14329	Work with ICS colleagues to identify a means of mitigating CDEL pressures across the ICS, including those within the Trust plan.		Kevin Scollay	**31.03.25**

Internal Audit 2024/2025					
Resource and Business Assurance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q1					

Clinical Audit 2024/2025					
Resource and Business Assurance Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q1					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2547**	**Version**	**3**	**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	**30/09/2024**						
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.

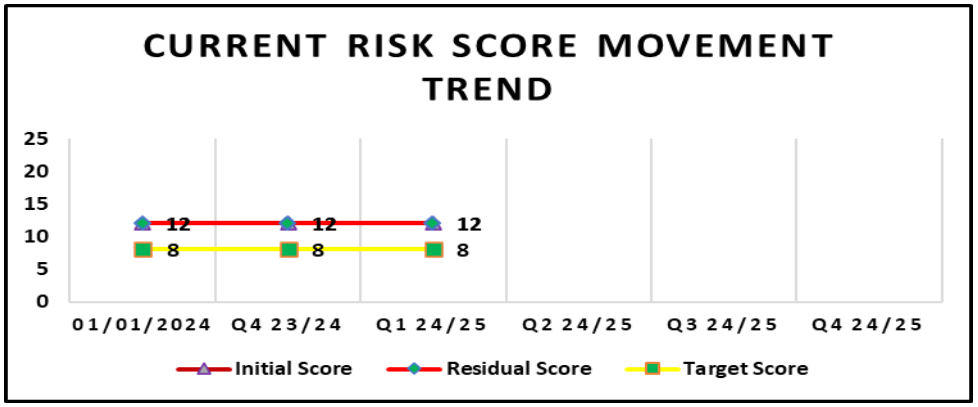
The cybercrime threat to the UK health sector includes ransomware, phishing, commodity malware, data theft and extortion, cyber enabled fraud and Distributed Denial of Service, which are routinely seen across the sector. Of these threats, ransomware almost certainly remains the largest and most likely 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

Gaps in Controls/Assurances include: -
- Capacity within the Digital Services Team to provide dedicated resource to the management of potential cyber-threats.
- Gap in reporting of assurance relating to cyber-threats within the Trust's governance framework.

	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		**N0**		
	New Actions Added		**Yes – Action 15266 has been added**		**10.07.24**
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.
RABAC now receives regular updates on Digital and Cyber related issues.	Regular Digital report to RABAC including development of committee competence through cyber awareness sessions

Action Number	Action Description	Last Action Update	Person Responsible	Target Date
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 approach to on-going cyber threats. A job description has been prepared. Awaiting	This is still being discussed internally together with considering options for a more central regional approach.	**Gillian Colquhoun**	**31.10.24**

	funding approval to proceed to recruitment.			
15266	Explore the need (or otherwise) for a Digital Committee to support the delivery and ongoing assurance needs of the Trust from a Digital Perspective		**Gillian Colquhoun**	**31.10.24**

Internal Audit 2024/2025						
Resource and Business Assurance Committee	**2024/2025**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	
This risk is not aligned to any Internal Audits for Q1						

Clinical Audit 2024/2025						
Resource and Business Assurance Committee	**2024/2025**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	
This risk is not aligned to any Clinical Audits for Q1						

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 as of 1 August 2024

Date Opened	**01/01/2024**	**Risks Ref No:**	**2542**	**Version**	**3**	**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	**30/09/2024**						
Executive Lead	**Lynne Shaw**	**Lead Committee**	**People Committee**			**Strategic Ambition**	**SA 3 – A great place to work**

Risk Description

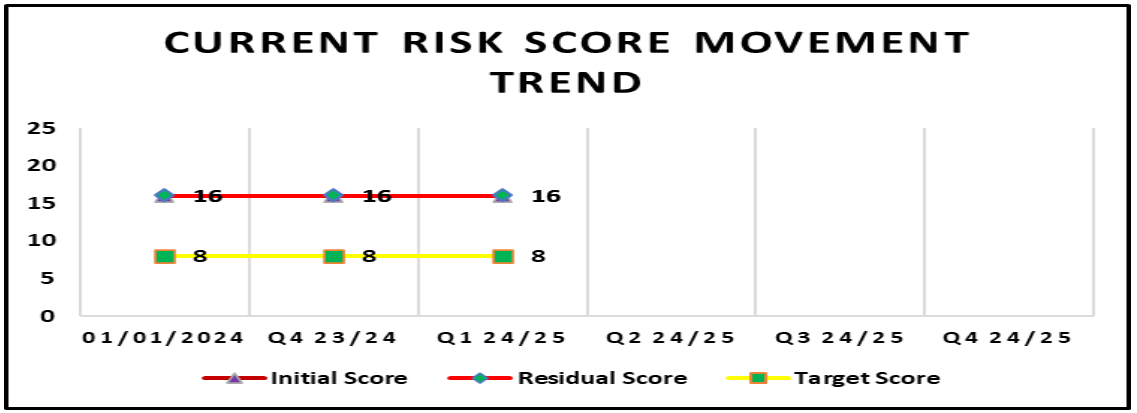
Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3

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 in Q1?	**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)
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**
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	Healthcare support worker supernumerary induction currently being aligned to HCSW programme prior to induction	**Vida Morris**	**30.09.24**
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	Currently being aligned to overall leadership development package to be rolled out in Autumn	**Emma Lovell**	**30.09.24**
14287	Support Worker Development Programme to be rolled out	Content currently being developed with first module scheduled rollout July/August	**Emma Lovell**	**30.09.24**

14288	Workforce plan to be produced	This action could take several months to complete	**Gemma Rutherford**	**31.03.25**

Internal Audit 2024/2025					
People Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Internal Audits for Q1					

Clinical Audit 2024/2025					
People Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**
This risk is not aligned to any Clinical Audits for Q1					

Date Opened	**01/01/2024**	**Risks Ref No:**	**2544**	**Version**	**3**	**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	**30/09/2024**						
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

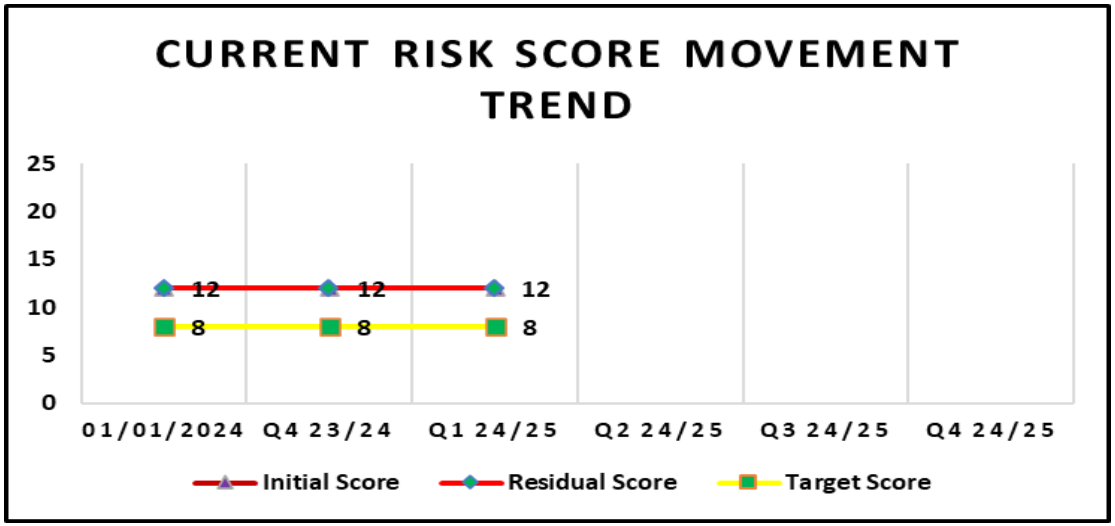
Context of the risk (narrative & background) Gaps in Controls/Assurances

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 in Q1?	**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 action 15258 has been added**		**28.06.24**
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 - sickness absence	Feedback/reports of improvements in People Metrics discussed at BDGW and People Committee.

- 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.	Training implemented for managers. Hearing rota no longer required. Discussion session took place with People Committee in June 2024. Resolution policy in draft.	**Lynn Shaw**	**30.09.24**
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		**Lynn Shaw**	**30.09.24**
14290	Improve uptake of health and wellbeing conversations		**Ramona Duguid**	**31.12.24**

14291	Review appraisal process in line with you in mind ensuring staff have clarity around roles, responsibilities and objectives		**Kim Carter**	**30.09.24**
14292	Develop coaching/mentoring offer for staff	Coaching offer is active, with new requests coming in via Trust Intranet. Those accessing are able to read Coach biographies before requesting who they would like as their. We have a 3rd cohort of new coaches 2/3's way through level 5 accreditation. We have 30+ qualified coaches within the organisation. Themes are - career development, changes in teams, and relationships. Reverse mentoring underway and being rolled out.	**Emma Lovell**	**30.09.24**
15258	CNTW 2023/24 05 Onboarding Process dated 19.04.24 - The purpose of the audit was to evaluate and test the control framework in place for delivering and recording local induction, ensuring it is timely, well planned, and structured and delivered in a methodical and orderly way ensuring that all relevant information is covered so that the member of staff is effectively integrated into their team and their role. Provide a **limited** level of assurance.	Several recommendations made including, clarifying the induction arrangements for newly qualified nurses, maintain a record and evidence of completed extended induction which should be assessed regularly, ensure results of monitoring and any associated action plans are reported regularly to the People Committee	**Gemma Rutheford**	**30.09.24**

Internal Audit 2024/2025						
People Committee	**2024/2025**					
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**	
CNTW 2023/24 05 Onboarding Process	*				**BAF 2544 SA3**	

Clinical Audit 2024/2025					
People Committee	**2024/2025**				
	Q1	**Q2**	**Q3**	**Q4**	**BAF/SA**

This risk is not aligned to any Clinical Audits for Q1					

Corporate Risk Register alignment to the BAF – People Committee

Although this risk is aligned to the People Committee BAF risk, it should be noted that the Quality and Performance Committee continue to oversee the work to address incidents of violence and aggression. There are currently 38 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, 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.

Corporate Risk Register 2624 Aligned to BAF risk 2544		
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**	**Impact**
	4. Likely	**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 as of 1 August 2024

Date Opened	**01/01/2024**	**Risks Ref No:**	**2548**	**Version**	**3**	**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	**30/09/2024**						
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 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.

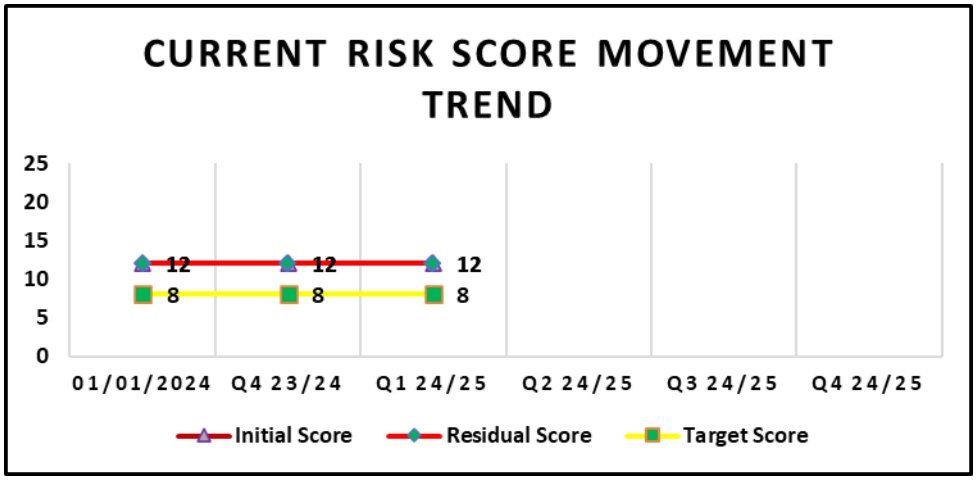
Context of the risk (narrative & background) Gaps in Controls/Assurances

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 Care Group Directors also have a consistent presence at Place (through Place Director roles) to ensure engagement, involvement and influence at a local level when determining priorities and plans for the system and local communities.

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 size of the Trust's geographic footprint and aligning this to new Care Group 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/ICB/ICP 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**		**Yes – description has been amended**		**05.06.24**
	Owner		**No**		
	Residual Score		**No**		
	Is risk to be closed		**No**		
Have actions progressed?	**Control and Assurances added.**		**Yes – 2 controls have been added**		**05.06.24**
	Actions Completed & Closed		**Yes – Action 13551 has been completed and closed**		**05.06.24**
	New Actions Added		**Yes – Action 15477 has been added**		**05.06.24**
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.
Establishment of the MHLDA sub-committee of the NENC ICB with CNTW Executive representation	MHLDA priorities discussed at MHLDA and acknowledgement of the challenges for services which can only be addressed at system-level with system support
Formal written report to EMG and the Board providing assurance of ICS/ICB and system working and partnerships.	Board members and senior leaders have increased awareness of the work at both system and Place level across the footprint.

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**	**Closed 05.06.24**
13552	Review of Provider Collaborative governance arrangements including roles as responsibilities (providers, lead providers, commissioners).	Review of Provider Collaborative is still ongoing.	**Debbie Henderson**	**30.11.24**
15477	Development of a document (for internal and external use) on the Trust's approach to Stakeholder engagement.		**Debbie Henderson**	**30.11.24**

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 - 2431 **No clear alignment to BAF risks**		
Ward/Department Risk 2431	**Residual Score 16**	
Due to CAV site being vacated prior to planned demolition to some areas of the site, there is a significant risk of interruption of power, water and heating systems being lost to all in-patient areas on the CAV site. CNTW will continue to deliver 24/7 services on this site whilst demolition takes place, 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. The empty site creates some complex security and estates issues which has experienced some 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.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
• ML meeting Associate Director Estates for NUTH on 23/6/23 to discuss estates infrastructure issues and possible mitigative actions. • NuTH are arranging a meeting with Head of Security at Uni to urgently discuss options. Have requested we are linked in. • NuTH Estates are looking at options to restrict vehicle access to the bottom end of the site i.e. main gates. • Installation of replacement water tanks and distribution mains along with Chlorine Dioxide dosing plant. This will require significant investment.		

Corporate Risk Register - 2439 **No clear alignment to BAF risks**		
Ward/Department Risk 2439	**Residual Score 16**	
Due to a difference in working practices, sharing of systems and a lack of communication across STSFT and CNTW, there may be a risk of patients not receiving appropriate care and treatment in a timely manner which could result in a deterioration of service users mental health and have an impact on the wellbeing of staff working into the service.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
• Weekly AD level interface meetings to look at processes and systems across services. • Upcoming potential TUPE of Assertive Outreach staff to CNTW. • To develop proactive, positive and transparent working relationships between both organisations senior management teams. Including respectful working relationships between clinicians from both organisations. • To develop a shared vision for service delivery and develop and embed some shared clinical processes. • To explore infrastructure for shared electronic record keeping.		

Corporate Risk Register - 2489 No clear alignment to BAF risks		
Ward/Department Risk - 2489	**Residual Score 16**	
Due to no stocks of medication for service users to utilise for symptoms of ADHD this may result in unmediated patients, deterioration of mental health, suicidal thoughts, loss of employment, increase of complaints into the service causing staff to become stressed and increase workload due increase contacts from service users re medication updates. This is likely to happen with a major impact on services and service users.	**Likelihood** **4. Likely**	**Impact** **4. Significant**
Gaps in Controls		
No gaps documented currently.		

5.0 De-escalation of BAF Risk 2540

It is recommended that the Board accept the recommendation from the Resource and Business Assurance Committee that BAF risk 2540 be de-escalated to Directorate/Group level and ownership transferred to Ramona Duguid, Chief Operating Officer. Agency costs are now consistently below the expenditure limit. Overall sustainability is the key BAF risk including levels of staffing overall, as opposed to the agency staffing subset (from a financial perspective). The regulatory risk associated with this has reduced, with some residual risk to be managed at Directorate level. Enhanced price cap monitoring to be included within finance report and reporting into RABAC to ensure oversight remains on compliance with regulatory requirements in this area.

6.0 Outstanding actions and next steps

6.1 Risk Management Policy – Amendment to Section 12

Risk Management Policy was amended on 1 August with the addition of Section 12 – Violence and Aggression Risk Assessment Towards Staff. This includes links to: -

- Risk Assessment Form (PMVA)
- Restraint Reduction (PMVA) Policy
- Managing Violence & Aggression – Existing control Measures

It is also important to note that the likelihood and impact thresholds and descriptors are different from those in Risk Management Policy section 4.3. These new thresholds and descriptors can be found in the Risk Assessment Form (PMVA) link and on the Web Risk Register intranet page.

6.2 E-Learning Package for Web Risk Training

The Group Directors and Associate Directors from the three Care Groups will attend a MS Team's training session provided by the Risk Management Lead and the Digital Learning Lead Trainer. This training will consist of three sessions over the next two months, only attendance at **one** session is required. Compliance with the training will be logged on the Electronic Staff Record system (ESR).

6.3 Reviewing Overdue Risk Reviews Pilot

Work to embed risk management processes and the newly revised policy continues with positive outcomes both in terms of understanding risk management across the groups and directorates and evidence in discussions and reporting of risks. Central and South Community Place teams will be piloting a project to implement a cycle of review and reporting of risks through the local governance frameworks. If this is successful, a proposal will be made to roll out to the other Care Groups.

7.0 Recommendation

The Board is asked to:

- Discuss the content of the report and:
  - Gain assurance that the BAF risks are being managed effectively and that the Trust has in place appropriate internal controls, systems and process for risk management.
  - Note the Corporate Risk Register high-level risks and alignment to the BAF, particularly in relation to risks associated with waiting times, access/demand and crisis services and seek further assurance thereon.
  - **Approve** the recommendation from the Resource and Business Assurance Committee to de-escalate risk 2540 as outlined in section 5.

Director Lead: Debbie Henderson, Director of Communications and Corporate Affairs
Date: 28 August 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**

BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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. SA1	Risk on identification (01/01/2024):	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?				

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 Development of a Community Oversight Group with associated task and finish groups to support clinical change to enhance input and reduce breaches.	1 Minutes of Community Oversight meetings reviewing community compliance against key targets that impact upon CTTs, Crisis teams and Liaison services.	CA-23-107 Sexual Safety clinical audit dated 14.06.24. Area of concern - Governance, risk management and control arrangements provided limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required. As per policy the risk rating shows high so the re-audit is due in Q3 24/25.
2 Established key task and finish groups to address the following areas: - role and function of CTTs; role and function of SPA/IRS; CYPS neuro; Trusted Assessment.	2 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.	Full implementation of community transformation models within seven place-based areas - Throughout 24/25
3 Working with primary care on the development of ARRS mental health workers to reduce demand on secondary care services.	3 Review of monthly ARRs summaries that highlight performance and stakeholder experience.	Continue to work with commissioner colleagues to obtain years 3 ARRS funding - Throughout 24/25
4 Established an Enhanced Bed Management service to promote timely discharge and re-drafted admission and discharge policy.	4 Copy of DTOC meeting minutes / reports.	

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

1	Reviewing the role and function of the discharge facilitator roles throughout the Trust.	1	Review of discharge information enabling a compare, and contrast between each of the adult mental health wards.	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
2	Working with Third Party Providers to provide additional support for hospital discharge	2	Review of, and reduction in the number of patients in receipt of out of area treatments.	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.
3	Dashboard review highlighting clients seeking admission which includes current clinical status, location etc.	3	Improved alignment between community and inpatient pathways as monitored by the Programme Boards.	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
4	Active participation in the development of community transformation models within the seven place-based areas.	4	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.	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
5	Identification of seven pioneer teams (1 per place-based area) to pilot community initiatives e.g., SBAR.	5	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.	Crisis work programme to be reviewed in light of community transformation and urgent care requirements.
				Successfully transition away from CPA - during 2024/25
				ADHD adult pathway recovery plan required with system partners.
6	Development of a clinical delivery model to support more efficient and effective care delivery.	6	Reduction in complaints and SI's reports reflecting this available.	

1	Reviewing working practices adopted on inpatient units to support improved flow.	1	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.	
2	Participated in the NHS England 100 Day Challenge to obtain key learnings and processes to help support more efficient and effective inpatient stays.	2	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.	
3	Appointed 2 Senior Case Managers to provide support and oversight of key tasks linked to effective bed management, MADE events etc.	3	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.	
4	Development of an emerging Quality Framework for Inpatient services.	4	Improved performance reporting via the Integrated Performance Report (IPR).	
5	Reviewing the role and function of the Trusts crisis teams to better align with the organisations transformational journey.	5	Feedback/notes from Keeping In Touch processes.	
6	Daily Locality flow meetings.	6	Feedback/notes from this meeting.	

1 CYP Neuro pathway review approved by EMG.	1 Implementation progressing across 7 places and discussed with ICB.	
2 ICB escalation process established for complex clinically ready for discharge patients.	2 Reduction in complex cases CRFD.	
3 Primary Care Strategy and engagement is in place.	3 Primary Care Strategy.	

Ref: 2510v.3

Risk Owner: Ramona Duguid

Next Review Date: 30/09/2024

Review/Comments:

28/06/2024 - Yvonne Newby - Reviewed. Actions updated and new target dates set. One action 14679 completed and closed. 2 new actions 15204 & 15246 have been added. Residual score remains the same at this review due to ongoing actions.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. SA1	Risk on identification (01/01/2024):	4	5	20	High (Red)
	Residual Risk (with current controls in place):	3	5	15	Moderate
	Target Risk (after improved controls):	2	5	10	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality (Effectiveness & Experience) (6-10)			Breach
	Risk Appetite Subcategory	Quality Effectiveness & Experience - CQC			
	Who is potentially at Risk?				

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 Monthly CQC Compliance meeting and fortnightly Steering Groups in place	1 Minutes from meetings show a reduction in CQC Action plans from 51 - 21	CA-23-091.01: Clinical Supervision 10.05.24 - Minor areas of concern - Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows moderate so the re-audit is due in Q2 25/26.
2 MHA Reviewer Visits in place - sharing of reports and aligning actions to CQC Must Dos/themes.	2 Improved outcomes following MHA reviewer visits and actioning of recommendations. Reports and aligning actions to CQC Must Dos/themes are available.	
3 Monthly reporting of Must Do actions through Q&P - reducing number and action plans	3 Feedback / updates on areas of improvement and good practice at CQC Compliance group and BDG - Q&P.	
4 Programme of mock CQC Inspections led by Senior Clinician and CQC compliance lead.	4 Feedback/Reports of completed mock CQC Inspections carried out across the Trust. Reporting themes to Q&P Committee to ensure continued focus.	CA-23-035.01 CYPS CPA Care and Treatment Audit 12.04.24 - Moderate areas of concern - Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively.

1	CQC Relationship Meetings bi-monthly.	1 Minutes from this meeting are available.	
2	Learning and bench marking through oversight of other organisational CQC Inspection Reports.	2 Copy of report outlining actions for learning and improvement from other CQC Inspection Reports. .	
3	CQC Update sessions delivered at Ward managers Community of Practice - August 2023	3 Increased awareness of preparedness for CQC inspections, and actions identified.	
4	CQC inspection preparedness programme in place. Task and Finish Groups include Governor representation	4 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.	
5	Peer Review visits	5 Feedback from visits carried out and improvements undertaken from actions noted.	
6	Inspection preparedness audit	6 Internal Audit conducted a risk-based audit of the Trust's preparedness for a comprehensive CQC inspection. Audit gave good level of assurance.	
7	CNTW 23-24 07 Performance Management & Reporting (15.04.24) The audit involved the review and testing of controls associated with the following indicators, mapping controls to one or more of the six dimensions of quality - accuracy, validity, reliability, timeliness, relevance, and completeness.	7 Final Internal Audit report date 15 April 2024 provides a substantial level of assurance relating to a review of the Trust's processes and controls for Performance Management & Reporting.	Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows moderate so the re-audit is due in Q1 25/26.
			Continue with regular informal connection and formal meetings with CQC leadership team - ongoing throughout 2024/25
			Quarterly updates to Board on progress against closure of action plans - ongoing throughout 2024/25
			Updates on building works to CQC - ongoing throughout 2024/25
			Delivery of CQC 'every day is a quality day' preparedness programme - Q3/Q4 2024/25
			CA-23-012.02 Nutrition Policy Audit 14/06/2024 - Minor areas of concerns - Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows high so the re-audit is due in Q3 24/25.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 2511v.3

Risk Owner: Sarah Rushbrooke

Next Review Date: 30/09/2024

Review/Comments:

26/06/2024 - Sarah Rushbrooke - Reviewed today. Actions 13095 & 15248 have been completed and closed, actions 15182; 15249 & 15254 has been added and all other actions have been updated and new target dates set. One new control CNTW 23-24 07 Performance Management & Reporting has been added. The residual score remains the same at this review due to ongoing actions.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern. SA1	Risk on identification (01/01/2024):	4	4	16	High (Red)
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Safety (6-10)			Breach
	Risk Appetite Subcategory	Quality Safety - Patient Safety			
	Who is potentially at Risk?				

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 Trustwide Safety and it's subgroup the Patient Safety Learning and Improvement Panel (PSLIP) has oversight of PSIRF implementation and learning from incidents	1 Regular updates on PSIRF implementation and PSLIP outputs	CA-23-091.01: Clinical Supervision 10.05.24 - Minor areas of concern - Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows moderate so the re-audit is due in Q2 25/26.
2 Clear governance and assurance in place on PSIRF implementation.	2 Reduction in the number of SIs; Independent Investigations and complaints reports available.	
3 Training needs analysis in place	3 Training dashboards where training needs are identified.	
4 Communication plan in place (including staff, Board, Governors, service users and carers and workforce).	4 Copy of plan is available. Plan ensured awareness across the organisation.	CA-23-107 Sexual Safety clinical audit dated 14.06.24. Area of concern - Governance, risk management and control arrangements provided limited assurance that the risks identified are managed effectively. Compliance with the control
5 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	5 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.	

framework.		framework was not found to be taking place. Immediate and fundamental remedial action is required. As per policy the risk rating shows high so the re-audit is due in Q3 24/25.
		Outcome measures to be developed over time rather than a single document.
		Trust Leadership Forum session planned in June to discuss organisational culture including sessions on just / learning culture.

Ref: 2512v.3

Risk Owner: Rajesh Nadkarni

Next Review Date: 30/09/2024

Review/Comments:

28/06/2024 - Rajesh Nadkarni - Reviewed with Claire Thomas. Controls and assurances amended. 2 new controls have been added. 1 action 13115 has been completed and closed. 2 new actions 15255 & 15256 have been added. Other actions have been updated and new target dates set. Residual score to remain the same at this review due to ongoing actions.

BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services. SA2	Risk on identification (01/01/2024):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Model Of Care (12-15)			Within Risk Appetite
	Risk Appetite Subcategory	Model Of Care - Services			
	Who is potentially at Risk?				

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 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.	1 Monitoring progress against project plans in place with leads and delivery dates.	CA-23-035.01 CYPS CPA Care and Treatment Audit 12.04.24 - Moderate areas of concern - Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required. As per policy the risk rating shows moderate so the re-audit is due in Q1 25/26.
2 We are engaging with key internal stakeholders via the Trust Leadership Forum, Ward Managers Meetings, Community of Practice, Service User and Carer Forums etc.	2 Greater and wider understanding of the key programmes and project outputs by Trust staff.	
3 Alignment of Trust priorities for delivery with the NENC ICB transformation agenda for MH&LDA.	3 MHLDA Board established with shared agenda on national policy requirements and interface with the transformational programmes of work.	
4 Realignment of CNTW operating structure to focus delivery on key transformational areas with commissioners (ICB and provider collaborative).	4 Structure go live April 2024.	GP shared Care situation formally escalated to ICB. Internal EPRR approach for potential GP industrial action to be considered.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 2543v.3

Risk Owner: Ramona Duguid

Next Review Date: 30/09/2024

Review/Comments:

28/06/2024 - Yvonne Newby - Reviewed. Actions 14688; 14689 & 14690 have been completed and closed. One new action 15205 has been added. Residual score to remain the same at this review due to ongoing actions.

BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Risk of increased staffing costs from use of temporary staff impacting on quality of care and financial sustainability. SA3	Risk on identification (01/01/2024):	4	4	16	High (Red)
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Financial (6-10)			Breach
	Risk Appetite Subcategory	Financial - Sustainability			
	Who is potentially at Risk?				

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 based agency control meetings.	1 Minutes from meeting regarding group based agency control.	Enhance monitoring of price cap breaches to support development of action plans to eliminate price cap breaches
2 Quarterly review of agency expenditure via finance reporting at RBAC	2 Reports and Minutes from RBCA	
3 Reporting of agency expenditure via BDG	3 Minutes from the BDG where agency expenditure discussed.	
4 Monthly Board scrutiny and review at Board development sessions.	4 Monthly Board scrutiny and review at Board development sessions.	
5 Reporting of agency expenditure via EMG.	5 Minutes from the EMG where agency expenditure discussed.	
6 Quarterly well led framework meetings include reporting around agency usage	6 Implementation of NHSE controls e.g. nonclinical and off framework actions.	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 2540v.4

Risk Owner: Kevin Scollay

Next Review Date: 08/10/2024

Review/Comments:

10/07/2024 - Kevin Scollay - Recommend this risk is de-escalated to directorate risk register and transferred to R Duguid. Agency costs are consistently below the expenditure limit now. Overall sustainability is the key BAF risk including levels of staffing overall, not the agency staffing subset (from a financial perspective). The regulatory risk associated with this reduced, with some residual risk to be managed at directorate level. Enhanced price cap monitoring to included within finance report and reporting into RABAC to ensure oversight remains on compliance with regulatory requirements in this area.

BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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	Risk on identification (01/01/2024):	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)	Workforce Staffing (6-10)			Breach
	Risk Appetite Subcategory	Workforce/Staffing - Staffing			
	Who is potentially at Risk?				

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 A training needs analysis outlining training requirements for statutory and essential training is in place for all professions/service areas.	1 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.	Workforce plan to be produced
		Community transformation work on the clinical model to be completed
		Introduce comprehensive induction programme for unregistered staff
2 CPD and Workforce Development Monies is ring-fenced for the development of medical/non-medical staff.	2 NHSE Returns identify monies spent and on which training topics.	Introduce a robust establishment control process.
		Recording of skills on ESR
3 Leadership and management skills programmes are in place across the Trust to support succession planning.	3 Staff survey responses to Manager/Leadership/career development questions. Reduction in employee relations issues (incl., grievances and disciplinaries). Reduction in incidents.	Edward Jenner Programme to be introduced for all new starters with no leadership qualifications
		Support Worker Development Programme to be rolled out
4 International recruitment programme for medical, nursing	4 International recruitment and the GMC	

	and allied health professionals		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)	
2	Apprenticeship model in place with 2-, 3-, 4- and 5-year schemes.	2	Increase in the number of nurses coming through the Trust because of the CNTW Academy 'grow your own' approach.	
3	Final Internal Audit Report - CNTW 2023-24 04 Pre Employment Checks	3	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.	
4	Statutory and Essential training requirements (10 core subjects) are in place as part of induction.	4	Corporate Induction is mandatory therefore all staff will have completed the 10 core areas prior to or at the Trust Induction.	
5	Various schemes in place with local colleges to support the widening participation agenda.	5	CNTW Academy data. Workforce data.	

Ref: 2542v.4

Risk Owner: Lynne Shaw

Next Review Date: 30/09/2024

Review/Comments:

28/06/2024 - Gemma Rutherford - Reviewed in partnership with Lynne Shaw, Exec Director Workforce and OD 13525, 14287, 14286 actions updated risk score remains the same due to the current position of the actions.

BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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	Risk on identification (01/01/2024):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Workforce Staffing (6-10)			Breach
	Risk Appetite Subcategory	Workforce/Staffing - Staffing			
	Who is potentially at Risk?				

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 monitoring of People Metrics e.g., -turnover -sickness absence -reasons for absence -morale and motivation -investigations -Freedom to Speak up concerns	1 Feedback/reports of improvements in People Metrics discussed at BDGW and People Committee.	Review appraisal process in line with you in mind ensuring staff have clarity around roles, responsibilities and objectives
		Leadership Programme to be rolled out to support the new operational model
		More information to be stored in ESR.
2 Occupational Health service and monthly contract review	2 Monthly contract review meetings	Management Skills Programme to be rolled out across the Trust.
3 Staff Psychological Service	3 Annual report to People Committee	Improve Employee Relations processes supported by just culture principles and implement a Resolution policy.
4 Reasonable Adjustments process in place with central budget	4 Process in place held in central budget - not monitored in terms of impact	
5 Staff Networks with identified Chairs (Exec sponsors for each network)	5 Network Chairs appointed through expressions of interest. Exec Sponsors for each Network.	Put in measures to address key Workforce Race Equality Standard (WRES) and Workforce Disability

1	Freedom to Speak up Guardians (FTSU) have regular contact with Trust Board members (including named NED) and have high visibility across the Trust	1	Monthly FTSU monitoring through BDG-Workforce, bi-annual reporting through People Committee. 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.
2	Thrive Website	2	Access to the website via Intranet
3	Health and Wellbeing approach (STAR)	3	Update on activity discussed at the People Committee bi-annually
4	Supportive workforce policies in place. Management skills training to support implementation.	4	Copy of policies and staff aware of where to access the policy.

	Equality Standard (WDES) indicators: -Reduce discrimination bullying and harassment -Improve progression for BAME Staff
●	Refresh Freedom to Speak up approach including development of Champion roles
●	Improve uptake of health and wellbeing conversations
●	Develop coaching/mentoring offer for staff
●	CNTW 2023/24 05 Onboarding Process dated 19.04.24 - The purpose of the audit was to evaluate and test the control framework in place for delivering and recording local induction, ensuring it is timely, well planned, and structured and delivered in a methodical and orderly way ensuring that all relevant information is covered so that the member of staff is effectively integrated into their team and their role. Provide a limited level of assurance.

Ref: 2544v.4

Risk Owner: Lynne Shaw

Next Review Date: 30/09/2024

Review/Comments:

28/06/2024 - Gemma Rutherford - Actions updated. 1 new action 15258 has been added. Residual risk score remains the same due to the current position of the actions.

BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care. SA4	Risk on identification (01/01/2024):	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 - Sustainability			
	Who is potentially at Risk?				

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 based agency control meetings.	1 Monthly reporting of financial performance via BDG.	Medium term financial recovery trajectories to be agreed to support medium term financial planning.
2 Agency control procedures.	2 Copy of procedures	Additional efficiencies to be identified to remove the £6.2m unallocated efficiencies included in the financial plan.
3 Implementation of NHSE controls e.g. non clinical and off framework actions.	3 Minutes from quarterly well led framework meetings of overall financial position.	
4 Reduction of unidentified CIP within Trust financial plans	4 Monthly Board scrutiny and review at Board development sessions	Extend existing Financial Delivery Plan by extending the planning horizon by 2 years and enhancing reporting on efficiency delivery.
5 Ongoing management of in year financial position through exceptional escalation meetings.	5 Minutes from this meeting will be available	
6 Development of Group specific in year recovery plans and actions.	6 Monthly Board scrutiny and review at Board development sessions	
7 Identification of underlying financial deficit to support medium term planning	7 Quarterly review of overall financial position via finance reporting at RBAC.	

1 CNTW 2023-24 15 Locality Budgetary Control - Locality & Support services level. Final report dated 09.02.024	1 CNTW 2023-24 15 Locality Budgetary Control - Locality & Support services level final report, provides a substantial assurance that the risks identified are mangaged effectively. Compliance with the control framework was also found to be taking place.	

Ref: 2545v.3

Risk Owner: Kevin Scollay

Next Review Date: 08/10/2024

Review/Comments:

10/07/2024 - Kevin Scollay - Updated to include reduced in year risk associated with unidentified efficiencies as reported to Board of Directors in July '24. Work ongoing around longer term sustainability plan - also updated at July '24 Board.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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	Risk on identification (01/01/2024):	4	4	16	High (Red)
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Estates Infrastructure (12-15)			Within Risk Appetite
	Risk Appetite Subcategory	Estates Infrastructure - Finance			
	Who is potentially at Risk?				

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 Capital Plan for 23/24 agreed by the Board as part of the Annual Financial Plan, with outline plans for subsequent years included.	1 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.	Work with ICS colleagues to identify a means of mitigating CDEL pressures across the ICS, including those within the Trust plan.
2 Managing working capital (cash) effectively	2 Monitoring of cash levels via finance report to ensure cash levels are sufficient to resource the capital plan.	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

1 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	1 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.	
2 CEDAR Programme Board established with key partners	2 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	

Ref: 2546v.3

Risk Owner: Kevin Scollay

Next Review Date: 08/10/2024

Review/Comments:

10/07/2024 - Kevin Scollay - Reviewed - work ongoing - no change in scoring.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Risk that the Trust's information and systems is at higher risk of being compromised leading to unknown vulnerabilities. This could lead to loss of, and/or public disclosure of, information and loss of access to critical systems. SA4	Risk on identification (01/01/2024):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Digital Cyber Threats (6-10)			Breach
	Risk Appetite Subcategory	Digital Cyber Threats - Data Security			
	Who is potentially at Risk?				

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 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.	1 Evidence of blocked authentications can be shown via Office 365 reports.	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.
2 MS Windows Enterprise facilities enabled such as AppLocker which blocks untrusted applications from running on end user devices	2 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	Recruit a new Cyber Security Analyst post for a dedicated resource to provide a more proactive approach to on-going cyber threats. A job description has been prepared. Awaiting funding approval to proceed to recruitment.
3 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	3 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.	Explore the need (or otherwise) for a Digital Committee to support the delivery and ongoing assurance needs of the Trust from a Digital
4 External email configured with DMARC/DKIM sender	4 Recently implemented to supplier best practice,	

	authentication which blocks impersonation of emails from CNTW		due to be audited 23/24 via AuditOne.	Perspective
2	Immutable backups for critical data such as EPR system have been setup.	2	Recently audited via AuditOne for the Data Security and Protection Toolkit.	
3	Systems patched via monthly process including internet browser to limit risk against known exploits.	3	Copy of process in place.	
4	Mandatory IG and Data Security training of staff to help promote identification of malicious emails and cyber security awareness.	4	IG and Data Security training levels are measured and tracked annually to meet data security and protection toolkit compliance.	
5	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.	5	Evidence of blocked authentications can be shown via Office 365 reports.	
6	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.	6	External assessed annually via CIS benchmarking process needed for NHS Secure Email accreditation	
7	Penetration tests carried out annually by CREST accredited independent auditors on Internet exposed services to help identify any potential exploitable systems.	7	CREST accredited report	
8	Implementation has been externally assessed by AuditOne with a substantial assurance rating.	8	Report from AuditOne with a substantial assurance rating.	
9	RABAC now receives regular updates on Digital and Cyber related issues.	9	Regular Digital report to RABAC including development of committee competence through cyber awareness sessions	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 2547 v.4

Risk Owner: Kevin Scollay

Next Review Date: 31/10/2024

Review/Comments:

BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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 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. SA5	Risk on identification (01/01/2024):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	1	4	4	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Partnership Working (16-25)			Lower
	Risk Appetite Subcategory	Partnership Working - Other			
	Who is potentially at Risk?				

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Trust representation on the NENC ICB Board of Directors	1 Ongoing positive, and open relationships as part of the CNTW/NENC ICB accountability meetings.	Review of Provider Collaborative governance arrangements including roles as responsibilities (providers, lead providers, commissioners).
2 Executive Leads identified for core work programmes / workstreams	2 Increased visibility of MHLDA as a priority for the system	Development of a document (for internal and external use) on the Trust's approach to Stakeholder engagement.
3 Named individuals at Care Group level representing the Trust at Place.	3 Involvement of the Trust at local level in shaping and influencing wider health and care plans for local communities i.e., physical health strategy, prevention agenda, health inequalities and alternatives to crisis/urgent care.	
4 Strong relationships with third sector organisations.	4 Development of joint services in collaboration with third sector colleagues i.e., the Bothy, Northumberland and the Space, Newcastle.	

1 Establishment of the MHLDA sub-committee of the NENC ICB with CNTW Executive representation	1 MHLDA priorities discussed at MHLDA and acknowledgement of the challenges for services which can only be addressed at system-level with system support	
2 Formal written report to EMG and the Board providing assurance of ICS/ICB and system working and partnerships.	2 Board members and senior leaders have increased awareness of the work at both system and Place level across the footprint.	

Ref: 2548v.2

Risk Owner: James Duncan

Next Review Date: 12/09/2024

Review/Comments:

13/08/2024 - Debbie Henderson - Risk reviewed. Background and context amended. Controls amended and new controls added. Actions updated and new target date set. One action completed and closed. Residual score to remain the same at this review due to ongoing actions.

8. ANY OTHER BUSINESS / ITEMS FOR INFORMATION

Darren Best, Chair

8.1 UK COVID INQUIRY MODULE 1 REPORT

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

REFERENCES

Only PDFs are attached

8.1 Covid-19 Module 1 Report Briefing.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 4 September 2024**
Title of report	**Covid 19 Inquiry Module 1 Briefing: The Resilience and Preparedness of the United Kingdom**
Report author	**Sam Cooke, Acting Head of Infection Prevention and Control** **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	
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

Board of Directors Meeting
Wednesday 4th September 2024

Covid-19 Inquiry Module 1 Briefing: The Resilience and Preparedness of the United Kingdom

Summary

Following the COVID-19 pandemic, an independent public inquiry was set up to look at the UK's response to and impact of the pandemic, in order to learn and share lessons for the future. This briefing paper summarises the recommendations of Module 1 of the Covid-19 Inquiry, which focused on the resilience and preparedness of the United Kingdom, with reference to the position of CNTW.

1. Background

Given the scale and scope of the issues requiring examination, the Covid-19 inquiry has been divided into separate investigations, called Modules, as outlined below:

- Resilience and preparedness (Completed)
- Core UK decision-making and political governance (Active)
- Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK (Active)
- Vaccines and therapeutics (Active)
- Procurement (Active)
- Care sector (Active)
- Test, Trace and Isolate (Active)
- Children and Young People (Announced Module)
- Economic response (Announced Module)

Each Module has a focus on a different topic, with its own public hearings, where the Chair (the Rt Hon Baroness Heather Hallett DBE) hears evidence.

Recommendations for changes are subsequently developed and included in a Module Report. Alongside the full report is a summary report of Module 1 of the Inquiry with recommendations in brief, which is included as an appendix to this report (Appendix below). The Chair of the Inquiry is explicit in the aim of ensuring that Inquiry reporting is timely throughout the Inquiry period, so that recommendations can be acted upon as soon as possible.

Module 1 of the Inquiry relates to United Kingdom Government planning and preparedness, with reference to the impact of the devolved administrations. The UK's ability to deal with a pandemic was found to be inadequate, including that the UK government's pandemic plan and strategy was outdated. This plan addressed preparation for an Influenza pandemic only and was, therefore, not suitable or flexible enough for the global pandemic that occurred. Prior to publication of the Module Report, the CNTW Trust Pandemic Plan was reviewed and updated to ensure it is fit for purpose in terms of preparedness and resilience for future pandemics. The revised document now has stronger links to Trust Emergency

Preparedness, Resilience and Response (EPRR) and Business Continuity plans, to ensure a cohesive and efficient approach to pandemic management.

Further modules will be announced and published in the coming months and each module will investigate issues across the UK, including in the devolved administrations of Scotland, Wales, and Northern Ireland. This will cover both 'system' and 'impact' issues across the UK.

2. Risks and mitigations associated with the report.

CNTW's pandemic plan has been updated and reflects learning from the Covid-19 Inquiry Module 1 report. Recommendations from future reports will be considered and acted upon as they emerge.

3. Recommendation/summary

The Board of Directors is requested to note the content of this report and specific references to the Trust's updated Pandemic Plan.

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

Appendix

Report and Recommendations in Brief

The UK Covid-19 Inquiry is an independent public inquiry examining the response to, and impact of, the Covid-19 pandemic, to learn lessons for the future.

The scale of the pandemic was unprecedented; the Inquiry has a huge range of issues to cover.

The Chair of the Inquiry, the Rt Hon Baroness Heather Hallett DBE, decided to address this challenge by dividing its work into separate investigations known as modules. Each module is focused on a different topic with its own public hearings where the Chair hears evidence.

Following hearings, recommendations for changes are developed and put into a Module Report. These reports will contain findings from the evidence collected across each module and the Chair's recommendations for the future.

The first module, Module 1, focuses on the resilience and preparedness of the United Kingdom. The investigation examined the state of the UK's structures and the procedures in place to prepare for and respond to a pandemic.

Future reports will focus on specific areas, including:

- Core UK decision-making and political governance - including Scotland, Wales and Northern Ireland
- Healthcare systems
- Vaccines and therapeutics
- Procurement and distribution of key equipment and supplies
- The care sector
- Test, trace and isolate programmes
- Children and young people
- The economic response to the pandemic

Module 1: The Resilience and Preparedness of the United Kingdom

Politicians have to make tough decisions about how to use resources to prepare for emergencies. Preparing for a pandemic or any other emergency costs money, even if it is an event that might not happen.

However, the UK Covid-19 Inquiry has found that **the system of building preparedness for the pandemic - that is, our ability to deal with a pandemic - suffered from several significant flaws:**

- Despite planning for an influenza (also known as flu) outbreak, our preparedness and resilience was not adequate for the global pandemic that occurred
- Emergency planning was complicated by the many institutions and structures involved
- The approach to risk assessment was flawed, resulting in inadequate planning to manage and prevent risks, and respond to them effectively
- The UK government's outdated pandemic strategy, developed in 2011, was not flexible enough to adapt when faced with the pandemic in 2020
- Emergency planning failed to put enough consideration into existing health and social inequalities and local authorities and volunteers were not adequately engaged
- There was a failure to fully learn from past civil emergency exercises and outbreaks of disease
- There was a lack of attention to the systems that would help test, trace, and isolate. Policy documents were outdated, involved complicated rules and procedures which can cause long delays, were full of jargon and were overly complex
- Ministers, who are often without specialised training in civil contingencies, did not receive a broad enough range of scientific advice and often failed to challenge the advice they did get
- Advisers lacked freedom and autonomy to express differing opinions, which led to a lack of diverse perspectives. Their advice was often undermined by "groupthink" - a phenomenon by which people in a group tend to think about the same things in the same way

If we had been better prepared, we could have avoided some of the massive financial, economic and human cost of the Covid-19 pandemic.

The Inquiry's Module 1 Report therefore recommends a major overhaul of how the UK government and devolved administrations in Northern Ireland, Scotland and Wales prepare for whole-system civil emergencies.

Recommendations

A comprehensive description of the recommendations can be found in the Module 1 Report. A summary of these are as follows:

- A radical simplification of the civil emergency preparedness and resilience systems. This includes rationalising and streamlining the current bureaucracy and providing better and simpler Ministerial and official structures and leadership
- A new approach to risk assessment that provides for a better and more comprehensive evaluation of a wider range of actual risks
- A new UK-wide approach to the development of strategy, which learns lessons from the past and from regular civil emergency exercises, and takes proper account of existing inequalities and vulnerabilities
- Better systems of data collection and sharing in advance of future pandemics, and the commissioning of a wider range of research projects
- Holding a UK-wide pandemic response exercise at least every three years and publishing the outcome
- Bringing in external expertise from outside government and the Civil Service to challenge and guard against the known problem of groupthink
- Publication of regular reports on the system of civil emergency preparedness and resilience
- Lastly and most importantly, the creation of a single, independent statutory body responsible for whole system preparedness and response. It will consult widely, for example with experts in the field of preparedness and resilience, and the voluntary, community and social sector, and provide strategic advice to government and make recommendations

These recommendations are designed to be implemented and work together; to produce real change in how the UK prepares for emergencies like pandemics.

The Chair expects that all recommendations are acted upon and implemented within the time frames set out in the recommendations. The Inquiry will be monitoring the implementation of the recommendations during its lifetime.

To find out more or to download a copy of the full Module 1 Report or other accessible format, visit: https://covid19.public-inquiry.uk/reports

8.2 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

8.3 DATE AND TIME OF NEXT MEETING

Wednesday 4th December 2024
St Nicholas Hospital Trust Board Room and via YouTube