Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

30 April 2025

10:00 GMT+1 Europe/London

Trust Board Room and via Teams

AGENDA

1. STANDING AGENDA ITEMS

Darren Best, Chair

REFERENCES

Only PDFs are attached

00. Board Agenda Public April 25 final.pdf

Board of Directors Meeting held in Public
Agenda

Board of Directors Board meeting held in public Venue: Trust Board Room, St Nicholas Hospital and Via Microsoft Teams		Date: 30 April 2025 Time: 10:00am – 3:00pm	
	Item	**Lead**	
1.	**Standing agenda items**		
1.1	Welcome and Apologies for Absence	Darren Best, Chair	Verbal
1.2	Confirmation of quoracy and declarations of Interest	Darren Best, Chair	Verbal
1.3	Minutes of the meetings held 4 December 2024	Darren Best, Chair	Enc
1.4	Action Log and Matters Arising from previous meeting	Darren Best, Chair	Enc
1.5	Integrated Performance Quarterly Report	Ramona Duguid, Chief Operating Officer	Enc
2. Strategic Ambition 1 – Quality care, every day			
2.1	Quality and Performance Committee Quarterly Assurance Report	Louise Nelson, Committee Chair	Enc
2.2	Mental Health Legislation Committee Quarterly Assurance Report	Michael Robinson, Committee Chair	Enc
2.3	Care Quality Commission – Learning Disabilities and Autism services report	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Verbal
2.4	Trust learning from the independent mental health homicide report into the treatment of Valdo Calocane	Rajesh Nadkarni, Deputy Chief Executive and Medical Director	Enc
	Break – 10 minutes		

3. Strategic Ambition 2 – Person led care, where and when it's needed			
3.1	West Cumbria Strategic Case for Change - for approval	Ramona Duguid, Chief Operating Officer	Enc
4. Strategic Ambition 3 – a great place to work			
4.1	People Committee Quarterly Assurance Report	Brendan Hill, Committee Chair	Enc
4.2	Staff survey outcome (incl. actions/ areas of focus for 2025)	Lynne Shaw, Executive Director of Workforce and Organisational Development	Pres
4.3	Equality, Diversity and Inclusion Board objectives 2025/26	Lynne Shaw, Executive Director of Workforce and Organisational Development	Enc
	Lunch – 30 minutes		
5. Strategic Ambition 4 – sustainable for the long term, innovating every day			
5.1	Resource and Business Assurance Committee Quarterly Assurance Report	Brendan Hill, Interim Committee Chair	Enc
5.2	Finance quarterly report (Quarter 4)	Kevin Scollay, Executive Director of Finance	Enc
6. Strategic Ambition 5 – working for, and with our communities			
6.1	Lived experience Service update	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc
6.2	Charitable Funds Committee update	Vikas Kumar, Committee Chair	Verbal
7. Governance and Regulatory			
7.1	Audit Committee Assurance Report	Robin Earl, Audit Committee Chair	Enc
7.2	Trust Annual Plan 2025/26 (and Quality Priorities for 2025/26) - for approval	James Duncan, Chief Executive	Enc
7.3	Board Assurance Framework / Risk	Debbie Henderson, Director of	Enc

	Management Report	Communications and Corporate Affairs	
7.4	Board Committees Terms of Reference - Quality and Performance Committee - Mental Health Legislation Committee - People Committee - Audit Committee - Resource and Business Assurance Committee - Board of Directors	Debbie Henderson, Director of Communications and Corporate Affairs	Enc
8. Any other business / items for information			
8.1	Chair's update - Non-Executive Director appointment process	Darren Best, Chair	Enc
8.2	Chief Executive report	James Duncan, Chief Executive	Enc
8.3	Questions from Governors and the public	Darren Best, Chair	
Date of next meeting 30 July 2025, St Nicholas Hospital Board Room and via MS Teams			

1.1 WELCOME AND APOLOGIES FOR ABSENCE

Darren Best, Chair

1.2 CONFIRMATION OF QUORACY AND DECLARATIONS OF INTEREST

Darren Best, Chair

1.3 MINUTES OF THE MEETING HELD WEDNESDAY 6TH DECEMBER 2024

Darren Best, Chair

To Follow

REFERENCES

Only PDFs are attached

1.3 Board in public minutes FINAL 4.12.2024 DH.pdf

Minutes of the Board of Directors meeting held in Public
Wednesday 4th December 2024
Trust Board Room, St Nicholas Hospital and via Microsoft Teams

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

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

In attendance:
Debbie Henderson, Director of Corporate Affairs and Communications / Trust Secretary
Kirsty Allan, Corporate Governance Manager / Deputy Trust Secretary
Anne Carlile, Lead Governor and Carer Governor, Adult Services
Margaret Adams, Service User and Carers Reference Group Chair
One member of the public was in attendance

STANDING AGENDA ITEMS

1.1 Welcome and apologies for absence
Darren Best welcomed everyone to the meeting which was being live-streamed via Teams Town Hall. Apologies for absence were received from James Duncan, Chief Executive and Robin Earl, Non-Executive Director.

1.2 Declarations of Interest
There were no declarations of interest to note

1.3 Minutes of the meeting held 4 September 2024
Brendan Hill requested an amendment to the People Committee Report update to clarify that the Committee would be focused on the priorities for the year at all meetings, as well as workshop deep dives.

Approved: Subject to the amendment, the minutes of the meeting held 4 September 2024 were approved as a true and accurate record of the meeting.

1.4 Action Log and Matters Arising from the previous meeting.
There were no actions due for review and no matters arising.

1.5 Chairs Update
Darren Best referred to the update on the recent engagement process relating to the future of mental health services in West Cumbria and thanked the team for the significant level of engagement which had took place to date. Opportunities to input into the engagement process would end around 31 December.

Darren referred to the development of Hope Haven, the 24/7 Community Hub in Whitehaven and commended the Trust and partners on the progress made. This will represent an innovative, groundbreaking development in care and support for those who need it in the community.

Following the recent Governor election process, Darren welcomed 12 new Governors to the Council. He acknowledged those Governors who have completed their full terms, and those who have chosen to stand down during the process. Their contribution to the Trust and its development during their time has been invaluable. Darren gave a special acknowledgement to Anne Carlile, Lead Governor and Fiona Grant, previous Lead Governor, who have undertaken the role, and given their time selflessly during their terms.

Darren congratulated Tom Rebair, on his appointment as Lead Governor commencing 1 December, and thanked Bea Groves-McDaniel, Fiona Regan, and Shannon Fairhurst who had also expressed an interest in the role.

Darren took an opportunity to thank David Arthur for his contribution to the Trust for six years as Non-Executive Director and Audit Committee Chair. David would be leading a Christmas Concert in support of SHINE, the Trust charity before his departure in January.

The Board received the Chair's Report.

1.6 Chief Executive Report including system segmentation update

In the absence of James Duncan, Rajesh Nadkarni referred to the report which included reference to the first cohort of 11 interns from Choices College. The College provides tailored programmes of work and development for people with a learning disability or Autism.

In October 2024 Cumbria Police advised CNTW and system partners that they have taken a decision to disband non-frontline teams due to the significant number of vacancies within the force. The Trust has been working closely with Cumbria Police to understand and mitigate the impact of these changes. Significant impact is likely to be seen in relation to demand and pressures on Trust services. A Rapid Response Team has been established to work with the Police and Crisis Team acknowledging the impact on others including acute providers and demand for mental health support.

Brendan Hill asked if there was a clear commitment to the resolution of the Police recruitment issues and timeline for this. Ramona Duguid advised that the decision was initially taken as an urgent response to the issues faced by Cumbria Police and their intention is to undertake a review of the service. In the interim, a collaborative approach is being taken to review the impact on Trust services and Ramona advised that the Trust and Police have a foundation of strong relationships. An escalation process with the North East and North Cumbria Integrated Care Board (NENC ICB) is also in place and discussions include a focus on the medium to longer-term impact.

Louise Nelson took reassurance regarding the realignment of staff in the triage team but recognised the concerns raised by North Cumbria Crisis Team in terms of increased pressure and demand and potential impact on Section 136. Louise also highlighted the importance of ensuring parity of esteem and equitable services in terms of the North Cumbria locality in comparison to other regions.

Rachel Bourne suggested that the impact on safeguarding be considered as part of the ongoing discussions. Darren agreed and reflected on the Police duty to safeguard life.

Darren Best noted that the discussion focused on street triage and highlighted the need for more assurance and focus on Crisis Services, and Section 136, and asked that the Board to kept up to date as discussions progress.

David Arthur noted the local discussions taking place but queried whether discussions were also taking place at regional and national level. Darren noted that Right Care, Right Person is undoubtedly impacting at a national level, but from a local perspective, responses may vary. For example, no changes have been made to input by Northumbria Police.

Rajesh referred to the NHS Oversight Framework which sets out how NHS England segments NHS providers and integrated care boards (ICBs) based on the level of support needed across the themes of quality of care, access and outcomes, preventing ill-health and reducing inequalities, people,

finance and use of resources, leadership and capability. Based on their recent assessment of the Trust, CNTW has been moved from Segment 1 to Segment 2 with identified need for targeted support. This change has been driven primarily by the financial challenges faced as an organisation, like many others across the country. In response to this segmentation change, the Trust will be expected to demonstrate early improvements on its financial delivery during 2024/25 and the 2025/26 operational plan. The NENC ICB confirmed they were pleased with the work undertaken by the Trust on reducing restrictive practice.

Michael Robinson referred to the introduction of the new Mental Health Bill in Parliament in November noting the increase in the threshold for detention and one of the four themes identified in the pre-amble to the Act relating to therapeutic benefit. Michael advised that threshold is likely to increase even further in the context of therapeutic benefit to the patient.

Darren referenced the approval of £20m of Service Development Funding and Mental Health Investment Standard monies to be distributed across the NENC Integrated Care System (ICS) including CNTW directly. Rajesh noted that the NENC ICB Mental Health, Learning Disability and Autism Committee have identified partnership working between CNTW and TEWV as a priority including national direction for ICBs to move toward a strategic commissioning role.

The Board received the Chief Executive report.

2. STRATEGIC AMBITION 1 – QUALITY CARE, EVERYDAY

2.1 Quality and Performance Committee Report

Louise Nelson referred to report noting the Patient Safety Incident Response Framework (PSIRF) as the quality focus at the October meeting. The report states where the committee have received full, partial or no assurance for key items of business. Where partial or no assurance is received, detail on the current gaps and actions is provided. Louise advised that due to the dynamic environment of quality, safety and experience issues, and the need for continual improvement, partial assurance is not uncommon. The Trust continued to move in a positive direction, but the report highlights where further work and oversight is required.

The Board were asked to note the extension of the Health and Safety Executive Improvement Notice.

Louise referred to the management of complex cases ready for discharge and noted that some gaps in control and assurance fall out-with the Trust control, for example, roles and responsibilities of other partners including Local Authorities, NENC ICB, housing authorities etc. The Committee did receive assurance issues are now being discussed and addressed at a system-level to support the discharge planning process for patients.

Other issues of focus for Committee included the implementation of Oxevision, work relating to Reducing Restrictive Practice, safer staffing, service user and carer experience, community services waiting times and CQC compliance and actions to address outstanding Must Do actions.

Louise advised that the work of the Committee is considered at each meeting in the context of the Board Assurance Framework and the Committee feel that all strategic risks aligned to the Committee are being managed appropriately.

Rachel Bourne referred to the delays in discharge for patients in the context of violence and aggression and Reducing Restrictive Practice and asked if there is a formal mechanism for monitoring and reporting back the discussions and actions for partners as well as the Trust in terms of ensuring accountability. Ramona advised that particularly for learning disability pathways and complex cases, the Trust are working with the NENC ICB to consider and review care packages, housing etc. Regarding the older people's pathway, the challenge remains primarily in the Cumbria locality and working with the Local Authority to improve market conditions for care providers. Regarding the adult acute pathway, it is important that the purpose and appropriateness of admissions is considered as well as confidence in ensuring the right community wrap care and support is in place.

From an assurance perspective, Darren queried if the Quality and Performance Committee should be sighted on individual delayed discharge cases via simple RAG-rated process. Ramona suggested looking at the three pathways along with supporting trajectories. Rajesh Nadkarni also suggested regular reporting to the Committee on cases where the length of stay has been particularly significant.

Regarding the new Committee assurance report format, Darren stated that he found the report helpful in terms of helping the Board to focus on key issues.

The Board received the Quality and Performance Committee report.

ACTION: Summary of Delayed Discharges and supporting trajectories for the three pathways of learning disabilities, older people's and adult acute for review at a future Quality and Performance Committee.

2.2 Mental Health Legislation Committee Report.
Michael Robinson referred to the report noting an increase in panel members from minority groups. There remains an ongoing issue relating to training and appraisal of panel members and learning is being taken from other Trusts.

Michael referred to an Internal Audit report 'compliance report Mental Health Act – Section 136 place of safety action update'. The report received Limited Assurance. Although the report had been received by the Audit Committee, a gap was identified in terms of ensuring Limited Assurance reports are received by the relevant Committee for assurance and oversight in a timely way. This has now been addressed.

Outstanding actions remain to take forward completion of Part A and Part B forms associated with record of capacity/consent to treatment at the point of detention. The Committee will continue to oversee progress of the work.

Other areas of focus for the Committee included Mental Health Act (MHA) training, and ensuring central collation and visibility of issues identified in formal visits i.e., MHA reviewer visits, CQC actions, etc., to ensure issues are known and actions are being addressed and impact monitored.

Louise Nelson emphasised the importance of maintaining a focus on rights and consent and the impact of the new Mental Health Bill. Rajesh advised that the Mental Health Legislation Team provide support to all Care Groups to ensure continued focus. If improvement is not evident, this would be escalated to the Trust wide Safety Group.

Vikas Kumar asked is there was a disproportionate number of people detained from minority communities. He also noted the increase in diversity of panel members and asked if the learning around the recruitment process could be shared more widely. Michael advised that the panel member role is not widely known and can be challenging to recruit into. Good work has been undertaken to proactively reach out to community groups. From a Trust wide recruitment perspective, Lynne Shaw noted that the work associated with the Patient and Carer Race Equality Framework includes working more closely with local community groups. Darren commended the team for their efforts in relation to recruitment of panel members.

In terms of recording the demographics of those detained, Michael confirmed that there was no evidence that people from minority backgrounds are detained more than other groups. Darren asked that the Mental Health Legislation Committee continue to monitor this closely.

The Board received the Mental Health Legislation Committee Report.

2.4 Integrated Performance Report - Quality Care Everyday
Sarah Rushbrooke referred to the Quality Care, Everyday section of the report and noted the significant reduction in use of restrictive practice. David Arthur queried the potential for over-recording of incidents. Sarah advised that workshops have taken place to look at incident reporting and

categorisation to ensure the accuracy of data. An assurance report will be taken to the Quality and Performance Committee.

The Board received the Quality Care Everyday update from the Integrated Performance Report.

2.5. Annual Infection Prevention and Control Report 2023/24
Sarah Rushbrooke referred to the report which was reviewed in detail at the Quality and Performance Committee. There were no significant issues to escalate.

The Board received the Annual Infection Prevention and Control Report 2023/24.

2.6 Safeguard Adults and Safeguarding Children Annual Report 2023/24
Rajesh Nadkarni referred to the report which was reviewed in detail at the Quality and Performance Committee. There were no significant issues to escalate.

The Board received the Safeguard Adults and Safeguarding Children Annual Report 2023/24

2.7 Learning from deaths report
Damian Robinson attended the meeting and delivered a presentation to support the report. The report provided a summary of death activity experienced by the Trust across all its services for the calendar years 2020 to 2023. This comprises the period following the integration of North Cumbria services into the Trust.

Regarding increasing numbers of deaths in specific populations, Rachel Bourne queried whether the increase related to reporting issues or a concern that deaths were increasing in a specific area. Damian advised that there was no evidence on any increases in deaths in specific areas as a cause for concern. This was also supported by the Learning from Lives and Deaths of people with a Learning Disability and Autistic people programme (LeDeR).

Louise Nelson referred to the national figure of 27% of all deaths by suicide, were in contact with mental health services and noted that this supported the need for a system approach to supporting suicide prevention. Louise also queried how people who self-harm, where this does not result in death by suicide, are supported. Damian noted that the Trust are involved in the NENC ICS work to support Suicide Prevention.

Darren acknowledged the assurance received that there is robust analysis taking using data available and recognised that there are no key issues of concern in that regard for the Board at this stage.

As part of the next scheduled updated on learning from deaths, the Board would welcome further understanding of the visibility of specific areas, analysis of inequalities, learning from reviews that are taking place, the collaborative work with the NENC ICB, and information on 'near-miss' cases i.e., those people who could have, or almost did die by suicide, particularly those cases involving self-harm.

The Board received the Learning from Deaths report

ACTION: In the next scheduled report, the Board would welcome inclusion of:
- **Visibility of specific areas**
- **Analysis of inequalities,**
- **Learning from reviews that are taking place**
- **The collaborative work with the NENC ICB on suicide prevention**
- **Information on 'near-miss' cases i.e., those people who could have, or almost did die by suicide, particularly those cases involving self-harm.**

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

3.1 Integrated Performance Report – Person led care, when and where it's needed
Ramona Duguid referred to the Person led care, when and where it is needed section of the report and noted continuing challenges relating to Crisis very urgent referrals seen within 4 hours at 54% against a trajectory of 70%. A deep dive will be undertaken at the December meeting of the Quality and Performance Committee with a follow up scheduled to take place in January/February.

The improvement plan to review the neuro-developmental pathway has now been approved by the NENC ICB. Funding has been allocated to support local place-based teams in primary care. Ramona noted the importance of shared trajectory to reduce waits further.

Rajesh Nadkarni advised that from a system acute perspective, providers are experiencing significant pressure impacting on patient flow which may worsen for a period of time over the winter period.

Ramona noted reporting of eight out of area placements in November, representing the highest position for the last 12 months.

The Board received the Person Led Care, When and Where it's needed metrics update from the Integrated Performance Report.

4. STRAEGIC AMBITION 3 – A GREAT PLACE TO WORK

4.1 People Committee Report
Brendan Hill and Lynne Shaw provided an update following the October meeting of the Committee noting improvement in a number of key metrics associated with training compliance in all priority areas.

Regarding the Freedom to Speak Up process, work is ongoing to improve access and capacity in relation to Freedom to Speak Up Guardians (FTSUG) with an increase in the number of guardians from two to five. In response to a query from Paula Breen around the recruitment and continuity of FTSUGs. Lynne advised that the terms of office for the five newly appointed guardians have been staggered to ensure continuity.

Brendan passed on the thanks of the Board to Stephen Hyde and Fran Papleontiou for their hard work and commitment to the role.

The Board received the People Committee Report.

4.2 Integrated Performance Report – A Great Place to Work
Incorporate into agenda item 4.1.

The Board received the A Great Place to Work metrics from the Integrated Performance Report.

4.3 Raising Concerns bi-annual report
Lynne Shaw referred to the report which had been reviewed in detail at the People Committee. Lynne noted the two themes from issues raised relate to management processes and behaviours.

The Board received the Raising Concerns bi-annual report

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

5.1 Resource and Business Assurance Committee Report
Paula Breen noted that work to ensure the Trusts financial sustainability remains very challenging. A detailed discussion will take place at the February meeting of the Board on financial planning in the short and medium term. Darren noted the expectation for the discussion will focus on the medium-term plan to enable collective understanding for the Board.

Regarding top up insurance, a decision was taken not move forward with this. This will be reviewed annually given the recognition that there is an ongoing risk in this regard.

The corporate benchmarking report was received as the Trust appears to be an outlier in terms of costs associated with some areas of corporate services. A further update will be provided to a future meeting following further analysis.

The Board received the Resource and Business Assurance Committee Report.

5.2 Integrated Performance Report – Sustainable for the Long Term, Innovating everyday
Kevin referred to the sustainable for the long term, innovating everyday section of the report. A detailed discussion on the financial position and medium-term financial planning will take place at the February meeting of the Board.

The Board received Sustainable for the long term, innovating every day, metric of the Integrated Performance Report.

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

6.1 Charitable Funds Committee Report.
Vikas Kumar provided a verbal update on the work of the Charity and thanked everyone for their contribution at the Annual General Meeting earlier in the year and the focus on SHINE. Income in terms of grant monies, donations and fundraising continued to increase as a result of the refresh of the Charity and continuing progress against delivery of its strategy and plan.

Vikas thanked Sharon Brennan, Daria Ansari-Said and Jack Lambert for their hard work and dedication to the charity throughout the period 12 months. A discussion on a review of the strategy will take place in January about the longer-term vision and purpose of the charity.

The Board received an update on the Trust Charity.

6.2 Service User and Carer Reference Group / Involvement report
Sarah Rushbrooke referred to the report which was reviewed at the Quality and Performance Committee. There were no significant issues to escalate.

The Board received the Service User and Carer Reference Group/Involvement Report.

6.3 Health Inequalities Report including governance framework – for approval
Lynne Shaw referred to the report making particular reference to the proposed governance framework for Health Inequalities. The proposal was discussed at the Executive Management Group. It was acknowledged that all Board Committees would have an element of assurance responsibility associated with the work to address Health Inequalities. Following a review of other organisations and governance structures for Health Inequalities, it was proposed that ongoing assurance oversight be incorporated into the terms of reference for the Quality and Performance Committee.

Darren reflected on previous Board discussions and the suggestion that as health inequalities is a wide-ranging agenda and will be critical to the achievement of the Trusts strategic ambitions, it was proposed that assurance oversight should remain with the Board rather than a single committee. Darren also referred to the role of the Chair and Chief Executive in the achievement of objectives relating to the health inequalities agenda noting that neither role attend Board committees.

Rachel Bourne queried the lack of inclusion of learning disabilities within the six priority areas. Lynne advised that this is included in the implementation of the Core20Plus5 for children and young people.

The Board agreed that Committees will continue to have oversight at the most relevant Committee for delivery of specific actions and areas of work, but the Board will maintain oversight and assurance from a holistic perspective associated with delivery of the six priority areas.

It was noted that the work to date and future plans appear to be inward looking and there was a need to look at health inequalities from an external perspective.

The Board received the Health Inequalities report

APPROVED: The Board asked that the proposal for the governance framework be amended to reflect:

- **Oversight and assurance at relevant Committees for delivery of specific actions and areas of work**
- **Oversight and assurance at the Board from a holistic perspective associated with delivery of the six priority areas.**

6.4 North East and North Cumbria System – Leadership Compact
For information only.

7. GOVERNANCE AND REGULATORY

7.1 Audit Committee Report
David Arthur referred to the report noting an issue relating to a high level of non-compliance with the Declaration of Interest process for medical staff. Further work is being developed to implement a separate process, in addition to the Trust policy, to support this and this will be subject to continual review by the Committee.

David acknowledged the improvement in completion of recommendations to internal audit reports.

NTW Solutions Limited accounts were scheduled to be reviewed by the Audit Committee in December for onward submission to the NTW Solutions Board for approval.

The Board received the Audit Committee Report.

7.2 Board Assurance Framework (BAF)/Corporate Risk Register (CRR)
Debbie Henderson referred to the report noting that BAF risks have been reviewed through all Board Committees. The report also provides detail of the Corporate Risk Register the highest-level operational risks in the Trust. These primarily relate to demand and access, financial sustainability, and development of the workforce model. Debbie noted that the issues continue to reflect discussions being held at Executive Management Group, Board Committees and the Board.

The BAF/CRR was discussed in detail at the Audit Committee who were satisfied that the Trust internal audit plan continues to reflect the key risks in the organisation.

Board Committee Chairs have used the new Committee reporting template to consider whether appropriate assurances had been received, that issues of focus continue to reflect the key risks and areas of focus for the organisation and if any changes are required to the BAF and committee focus.

The Board received the Board Assurance Framework/Corporate Risk Register update

8. Any other business
A member in attendance queried if the NHS Trust is aware of the Liz Kendal report regarding implementation of work coaches in mental health wards to support people with mental illness into work and referred to concerns raised on around safeguarding patients. Debbie Henderson agreed to contact the member of public out-with the meeting to clarify the question raised.

Date and time of next meeting
Wednesday 5 March 2025, St Nicholas Hospital, Jubilee Road, Gosforth, NE3 3XT
Trust Board Room and live-streamed via MS Teams

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 April 2024.pdf

Board of Directors Meeting held in public

Action Log as at 4 December 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					
04.12.25 (2.7)	Learning from deaths report	Inclusion of the following n the next scheduled report: - Visibility of specific areas - Analysis of inequalities, - Learning from reviews that are taking place - The collaborative work with the NENC ICB on suicide prevention - Information on 'near-miss' cases i.e., those people who could have, or almost did die by suicide, particularly those cases involving self-harm.	Rajesh Nadkarni	June 2025	On track
Completed Actions					
06.03.24 (6)	RABAC Report	Digital Innovation update to be provided at a future Board meeting	Kevin Scollay	Aril 2025	Complete – discussion in Closed session April
04.12.25 (2.1)	Quality and Performance Committee Assurance Report	Summary of Delayed Discharges and supporting trajectories for the three pathways of learning disabilities, older people's and adult acute for review at a future Quality and Performance Committee.	Ramona Duguid	March 2025	Complete – discussed at April Q&P

1.5 INTEGRATED PERFORMANCE QUARTERLY REPORT

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

1.5 Trust IPR - March 2025 - Final v.2.0.pdf

1.5. IPR - April 2025 Meeting.pdf

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2024-25 Month 12 (March 2025)

With YOU in mind

Oversight and Assurance changes in 2025/26

Oversight and Assurance

The Trust will provide oversight and assurance for the delivery of the Trust plan, including the core priorities under each ambition, as well as finance, productivity, performance, workforce, and transformation programmes, through the process described in this diagram.

The Integrated Performance Report (IPR) will be reported in full monthly to the EMG for executive oversight and quarterly to the Trust Board for assurance on key areas.

Period	Purpose	Reporting / Assurance / Oversight	Meetings
Monthly	Oversight of operational delivery, oversight/assurance of risks, drive improvement against transformation programmes, priorities and measures. Escalate only in exceptions to Closed Board for assurance	Care group/Executive Oversight - Care Group Delivery - Programme Delivery Reports - Finance Reporting - Trust IPR - EMG Board Assurance - Closed Trust Board by exception	Care group/Executive Oversight - Care Group OMG - Business Delivery Group - Programme Boards - EMG Board Assurance - Closed Trust Board
Quarterly	For executive oversight and board assurance, report on the progress with the priorities within the 5 key ambitions, assurance against risks and delivery on Transformation Programmes	Executive Oversight - Well Led Care Group delivery - Programme delivery - EMG Board Assurance - RABAC - Ambition 4 / Risk - Q&P Cttee - Ambitions 1,2&5 - People Cttee Ambition 3 - Trust Board - All ambitions/risk assurance/IPR	Executive Oversight - Well Led Care Group Meetings - EMG Board Assurance - RABAC - Quality & Performance Cttee - People Committee - Trust Board Meeting

New Draft NHS Performance Framework – Provider scorecard metric heading

Summary scoring of each area	Operating priorities
	Outcomes
	Quality
	Quality and inequalities
	Productivity and value for money
	Short term delivery score
	Medium term delivery score
	Raw delivery score (average of short and medium term scores)
	Organisational delivery score (Quartiled raw delivery score)

Summary	Finance score
	Current NOF segment
	Downgrade due to deficit?
	Performance Assessment Framework segment

Subject area	Metric
Operating Piorities	Percentage of adult inpatients discharged with a length of stay exceeding 60 days
	Raw delivery score (total score/total number of scores)
	Domain scores (Raw delivery score quartiled)
Outcomes	Percentage of talking therapies patients achieving reliable recovery
	Percentage of Healthcare workers involved with direct patient care taking up flu vaccination
	Proportion of inpatients making a supported attempt to quit smoking though an in-house tobacco dependence treatment
	Emergency rate of readmissions within 30 days of discharge (Banding)
	Raw delivery score (total score/total number of scores)
	Domain scores (Raw delivery score quartiled)
Quality and Inequalities	Percentage of NHS Trust staff to leave in the last 12 months
	Sickness absence rate
	NHS staff survey engagement theme score
	National Education and Training Survey satisfaction rate
	NHS Staff Survey raising concerns sub-score
	CQC safe inspection score
	% change in the number of people accessing community MH services with SMI who receive 2 or more care contacts in a rolling 12 month period
	% of patients with an open referral for suspected autism open for at least 13 wks with no recorded care contact appts
	Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours
	Crude rate of restrictive interventions per 1,000 occupied bed days
	Number of adults over the age of 65 with a length of stay beyond 90 days at discharge
	% change in the number of children and young people accessing NHS funded mental health services with at least one contact (rolling 12 month period)
	Raw delivery score (total score/total number of scores)
	Domain scores (Raw delivery score quartiled)
Productivity & Value for Money	Planned surplus/deficit
	Variance year-to-date to financial plan
	Level of confidence in delivery of financial plan
	Rate of productivity
	Comparative difference in costs
	Raw delivery score (total score/total number of scores)
	Domain scores (Raw delivery score quartiled)

Integrated Performance Report - Headline Commentary

Reporting Period: Mar 2025

Headline Challenges

- **Sickness** – 6.6% against a target of 5%
- **Clinical Priority Training –** 3 of 9 courses have met the Q4 trajectory.
- **Appraisal rate** – Increased in the month to 75.5%.
- **Clinical Supervision** – 81.3% against 80% standard.
- **% of patients with a Safety Plan** – At 84.7% against a 100% target.
- **Assaults on Staff** – increased in the month from 429 (Feb) to 473 in March.
- **Reducing Incidents of self-harm –** 98.8% resulted in low or no physical harm, 0.7% (9) of the incidents were moderate physical harm and 0.5% (7) were reported as severe physical harm.
- **Rights at Point of Detention** – Performance continues to fluctuate, reported at 90.9%, 9.1% below target
- **Record of Capacity/Consent to Treatment (CTT) at point of detention**– is consistently off target, deteriorated in the month, 1.1% decrease from February
- **Active Inappropriate Out of Area Placements –** There were 10 reported active inappropriate placement as at 31/03/2025
- **Bed occupancy –** remains off target at 93.2%.
- **Adult inpatients discharged with LOS >60 days** – Reported at 25.6%, (23 patients discharged with a LOS >60 days in the month).
- **Older Adult inpatients discharged with LOS >90 days** – Reported at 46.0%, (17 patients discharged with a LOS >90 days in the month).
- **Clinically Ready for Discharge** – remains off target with most of the patients waiting for external packages of care, housing and care homes places.
- **Crisis Very Urgent Referrals seen within 4 hours –** Performance improved in month, reported at 54.6% against a trajectory of 80%.
- **Crisis Urgent Referrals seen within 24 hours –** Performance deteriorated in the month, reported at 76.9% in March against an 85% target.
- **Psychiatric Liaison seen within ED within 1 hour –** Reported 0.5% below target at 79.5%.
- **4wks Referral to Treatment - Adult and Older Adult** – 23.5% of referrals have been waiting 4 weeks or less to treatment. The 65% trajectory for Q4 has not been met
- **4wks to Referral to Receive Help - All CYPS** – 6.6% of referrals have been waiting 4 weeks or less to receive help. The 45% trajectory for Q4 has not been met

Key focus areas of concern

- **Clinically Ready for Discharge**
- **Active Inappropriate Out of Area Placements**
- **Crisis Very Urgent (4 hours) and Urgent (24 hours) Referrals**
- **% waiting < 4 weeks to Receive Help – All CYPS**
- **% waiting < 4 weeks to treatment – Adult & Older Adult Services**

Positive Assurance / Improvement

- **How was the care we provided –** Reported above target for the first time in 12 months
- **Do you feel safe? –** reported consistently above target for 12 months.
- **Training Courses –** 9 of the 11 all staff training course are on target. Local Induction and Web Risk Register training remain off target.
- **Clinical Supervision** – Reported at 81.3% as at 31/03/25 above the 80% target
- **MRE Restraints** – Lowest position reported in 24 months
- **Psychiatric Liaison seen within Ward in 24 hours** – Continues to be reported above target
- **EIP Starting treatment in 2 weeks** – Reported consistently above target.
- **Live within our means** – Trust has delivered a £4.2m surplus in line with the financial plan

- ***Prone Restraints/Assaults on Patients/self-harm –*** *See next page for detailed summary deep dive of assurance areas to keep a focus on for the Trust.*

Mitigations/actions

Out of Area Placements / Clinically Ready for Discharge– Daily urgent flow escalation meetings are in place within representation from all Care Groups. An action plan has been developed to oversee key interventions. This Includes a focus on the highest impact areas by pathway for CRFD patients, development of a social care model to support patients in rehabilitation wards with social care/residential care needs, reviewing the recent changes to the admission pathway through Acute Hospitals Emergency Departments, and enhance the discharge facilitator teams to support patient pathways. This focus on improving flow will reduce patients who are CRFD and or out of area position by June 2025. *Recovery plan in place*

Crisis Very Urgent and Urgent Referrals – The Trust Innovation Group are supporting improvement work regarding this pathway and the teams are aiming to standardise Crisis pathways across all localities. A new improvement trajectory has been developed for 25/26 to drive improvement. The March 2025 EMG agreed for options to be developed on the section 136 facilities to consolidate the estate and improve the staffing availability across crisis pathways. *Recovery plan in place*

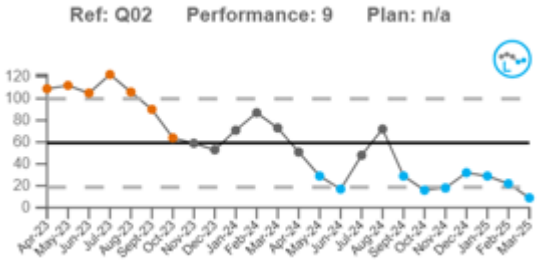
% waiting less than 4-week All CYPS – This measure remains low due to a rise in Neurodevelopmental referrals. To support pathway improvements, the Trust has been working with the ICB as part of an all-age neurodivergence group. The Trust have set improvement goals with the small amount of Service Development Funding (SDF) that has been secured. However, a significant system shift is required to tackle this complex challenge. A review of the adult and CYP Neurodevelopmental waiting times position has been considered by EMG with further work to be progressed with partners.

% waiting < 4 weeks to treatment – Adult & Older Adult Services - Over the past 18 months, the average patient waiting time has improved, supported by strong national benchmarking. However, performance remains below the ambitious target of assessing 65% of individuals within four weeks. To drive further progress, the Access Oversight Group conducts bi-weekly reviews of team performance, ensuring continued improvements in delivery. Recovery *plan in place with trajectories for 25/26.*

Patient/Staff safety – Headlines and actions summary

Reporting Period: Mar 2025

Prone Restraint



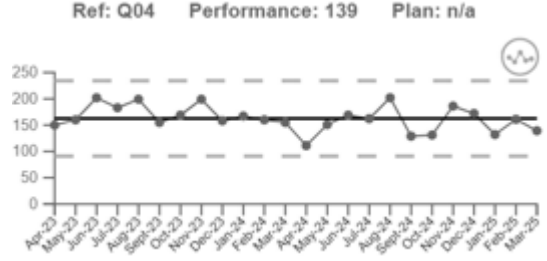
Analysis

There were 9 Prone restraints reported in March 2025, a decrease from 22 in February 2025. This relates to 7 patients in total. Two separate wards - Mitford (5) and Fraser (1), accounted for 66.7% (6) of the incidents and 33.3% (3) within the inpatient care group.

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.
- Prone restraints receive regular review in key management and governance groups, which have been further strengthened.
- 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.
- Prone trajectories in place and approved at Trustwide safety in line with the work on reducing restrictive practices across the Trust.
- The positive and Safe team have recently completed a manual to support the new Trust RRI and violence reduction policy.
- Copies will be made available on all inpatient wards.
- A positive downward trajectory is being maintained across the trust.

Assaults on Patients



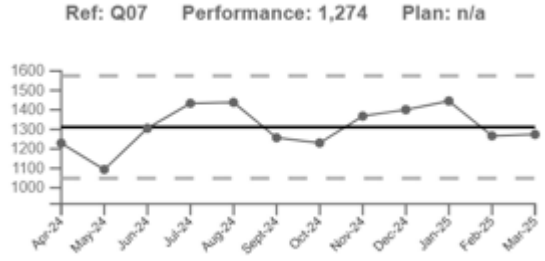
Analysis

There were 139 assaults on patients in March 2025, this includes both inpatient and community services. This was a decrease compared to February. Of the 139 assaults in March 2025, 65.5% of the assaults involved no physical harm and 34.5% resulted in low physical harm. There were no incidents reported as moderate or severe physical harm. Between January 2025 and March 2025 Beckfield, Ruskin, Shoredrift, Woodhorn and Longview inpatient wards, have reported the highest rates of incidents.

Improvement actions

- Health and safety training for managers commenced in February 2025 with managers to complete, current completion 56%.
- The Violence Reduction Group met in April 2025 , with a focus on staff support, reviewing the moderate harm data for both patients and staff, and considerations by the care groups for which patients present most risk to other patients and staff.

Incidents of self-harm



Analysis

In March there have been 1,274 reported incidents of self-harm (includes both inpatient and community services). 48.7% (620) of the incidents in March were no physical harm, 50.1% (638) were low physical harm, 0.7% (9) of the incidents were moderate physical harm and 0.5% (7) were reported as severe physical harm. Fraser (CYPS) and Lowry and Alnmouth (Adult Acute) are the wards with the highest incidents of self-harm.

Improvement actions

- Incidents of self-harm is a PSRIF priority with a a steering group and project management support 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.
- Individualised care planning / Review of care plans based on formulation and incidents of increased risks is in place.
- By end quarter 2 in 2025, we expect to see compliance with agreed process measures and NICE metrics, with a view to seeing a reduction in inpatient and community incidents of self-harm.

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Mar 2025

	Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Improvement	Consistently Off Target	89.4%	90%	CNTW Std	Med (Monitoring)	Improved in the month, highest position reported in 24 months	SR
	C02	How was the care we provided?	SPC n/a	SPC n/a	91.0%	90%	CNTW Std	Med (Monitoring)	Improved in the month, above target for the 1st time in 12 months	SR
	C03	Did you feel safe?	Improvement	Achieve at Random	95.8%	90%	CNTW Std	Low (On Track)	Reported consistently above target for 12 months	SR
People	P01	Sickness in Month	Normal Variation	Consistently Off Target	6.6%	5%	NHSE Std	High (Action)	Improved in the month, excludes NTW Solutions data	LS
	P02	All Staff Priority Training	SPC n/a	SPC n/a	9	11	CNTW Std	Low (On Track)	9 out of 11 prioritised training courses achieved target in March	LS
	P03	Clinical Staff Priority Training	SPC n/a	SPC n/a	3	9	CNTW Std	High (Action)	3 of 9 prioritised training courses have achieved the Q4 trajectory	LS
	P04	Appraisal rate	Normal Variation	Consistently Off Target	75.5%	85%	CNTW Std	High (Action)	Remains off target but has improved in the month - excl. NTW Solutions	LS
	P05	% Clinical Supervision completed	SPC n/a	SPC n/a	81.3%	80%	CNTW Std	Low (No Target)	81.3% is the reported position as at 31st March 2025	LS
Quality Care	Q01	MRE Restraints	Improvement	SPC n/a	3	n/a	n/a	Med (Monitoring)	Lowest position reported for 24 months	SR
	Q02	Prone Restraints	Improvement	SPC n/a	9	n/a	n/a	Med (Monitoring)	Position decreased (4th consecutive month), below lower control limit	SR
	Q03	Long term segregation and prolonged seclusion	Normal Variation	SPC n/a	14	n/a	n/a	Med (Monitoring)	Marginal deterioration in March, remains below avg (13 reported Feb 25)	SR
	Q04	Assaults on Patients	Normal Variation	SPC n/a	139	n/a	n/a	Med (Monitoring)	Decreased in the month and reported below average	RN
	Q05	Assaults on staff	Normal Variation	SPC n/a	473	n/a	n/a	Med (Monitoring)	Increased in the month but remains below average	RN
	Q06	% of patients with a Safety Plan	SPC n/a	SPC n/a	84.7%	100%	CNTW Std	Med (Monitoring)	Position increased in the month	RN
	Q07	Reducing incidents of self-harm	SPC n/a	SPC n/a	1,274	n/a	n/a	Med (Monitoring)	Slight increase in the month	RN
	Q08	Rights at Point of Detention	Normal Variation	Achieve at Random	90.9%	100%	CNTW Std	Med (Monitoring)	Performance deteriorated in the month, continues to fluctuate	RN
	Q09	Record of Capacity/ CTT at point of detention	Normal Variation	Consistently Off Target	67.5%	100%	CNTW Std	High (Action)	Remains consistently off target, decreased in the month	RN
Person Led Care	A01	Active Inappropriate Out of Area Placements (OAPs)	Normal Variation	Achieve at Random	10	0	NHSE LTP	Med (Monitoring)	There were 10 active Out of Area Placements at the end of March	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Normal Variation	Consistently Off Target	93.2%	85%	NHSE Std	High (Action)	Deteriorated in the month and reported above target	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	Achieve at Random	25.6%	20%	CNTW Std	Med (Monitoring)	Deteriorated in the month and reported above target	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	46.0%	40%	CNTW Std	Med (Monitoring)	Deteriorated in the month and reported above target	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Concern	Consistently Off Target	13.6%	7.5%	NHSE Std	High (Action)	Remains off track, position deteriorated in month from February	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	Consistently Off Target	54.6%	80%	CNTW Traj	High (Action)	18 out of 33 very urgent referrals seen within 4 hours	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Normal Variation	Achieve at Random	76.9%	85%	CNTW Std	Med (Monitoring)	340 out of 442, deteriorated in the month and remains below target	RD
	A08	% PLT ED Referrals seen within 1 hour	Improvement	Achieve at Random	79.5%	80%	CNTW Std	Med (Monitoring)	Improved in the month, 0.5% below the internal target	RD
	A09	% PLT Ward Referrals seen within 24 hours	Improvement	Achieve at Random	93.4%	85%	CNTW Std	Low (On Track)	Remains reported above the internal target	RD
	A10	% Waiting 4 wks or less to treatment (WAAOP)	Normal Variation	Consistently Off Target	23.5%	65%	CNTW Traj	High (Action)	76.5% (2,176 of 2,846) have been waiting longer than 4 weeks	RD
	A11	% Waiting 4 wks or less to receive help (CYPS)	Normal Variation	Consistently Off Target	6.6%	45%	CNTW Traj	High (Action)	93.4% (8,698 of 9,313) have been waiting longer than 4 weeks	RD
	A12	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	81.1%	60%	CNTW Std	Low (On Track)	Reported consistently above target	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC n/a	SPC n/a	£4.2m	£2.4m	n/a	Low (No Target)	The Trust delivered a 4.2m surplus in line with the financial plan	KS
	S02	Income & Expenditure Forecast	SPC n/a	SPC n/a	£4.3m	£2.4m	n/a	Low (No Target)	The Trust has delivered against the requirements for the year	KS
	S03	All staff WTEs	SPC n/a	SPC n/a	8,759	n/a	No Target	Low (No Target)	WTE numbers have decreased by 5 WTE since last month	KS
	S04	Capital spend compared to plan (£)	SPC n/a	SPC n/a	£6.2m	£1.5m	n/a	Low (No Target)	Plan to deliver the approved capital programme, £1.8m over the CDEL	KS
	S05	Cash balance compared to plan (£)	Normal Variation	SPC n/a	£43.5m	£16.4m	n/a	Low (On Track)	The Trust cash balances are higher than plan at month 12	KS

Commitments to our Carers & Patients - Headlines

Reporting Period: Mar 2025

Headline Challenges

- **How was your experience? (FFT) –** Performance was reported at 89.4% for March, this was an increase from February 25 (87.5%). The 90% target has not been met but performance is reported at only 0.6% below the target.
- In March performance is reported above the latest national FFT score for England (published Mental Health Services FFT score for England is 89.0% for January 25).

Key focus areas of concern

No specific concerns to raise.

Positive Assurance / Improvement

- **How was the care we provided?** – 91.0% of people said care was Good or Very Good, performance is reported above the target for the 1st time in 12 months.
- **Did you feel safe with our service?** – this remains the best performing question, reported above target for the 12th consecutive month at 95.8%.

Mitigations/actions

How was your experience? (FFT)

- 474 of the 530 people answering this question chose a positive response.
- There were 32 (6.0%) negative experiences reported of the 530 responses to this question. This is an improvement on 38 (7.4%) in February 2025.
- There are no teams with high numbers of negative experiences this month.
- 90 teams had 100% positive responses to this question during March, of the 120 teams with feedback.

How was the care we provided?

- 509 people responded to this question with 463 (91.0%) reporting a very good or good experience of the care provided.
- 27 respondents reported a poor experience (13 very poor and 14 poor) an improvement from 33 poor experiences reported in February from 501 responses.
- 36 respondents did not answer this question or responded as did not know.

Did you feel safe with our service?

- 483 of 504 people responding felt safe, 328 of these responses were from service users.
- 21 people said they didn't feel safe across 13 teams/wards, meaning no team had high levels of negative responses.

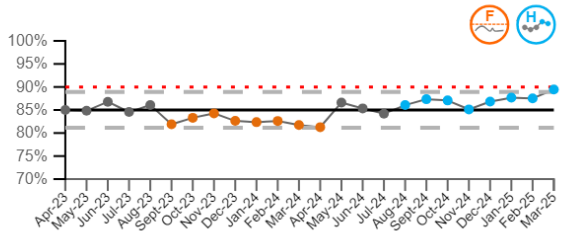
Commitments to our Carers & Patients

Reporting Period: Mar 2025

How was your experience? (FFT)

Med (Monitoring)

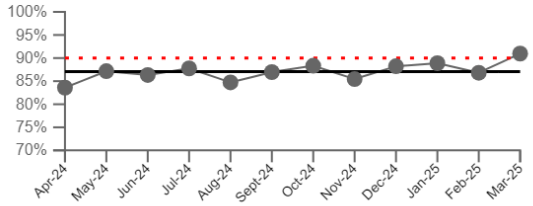
Ref: C01 Performance: 89.4% CNTW Std: 90%



How was the care we provided?

Med (Monitoring)

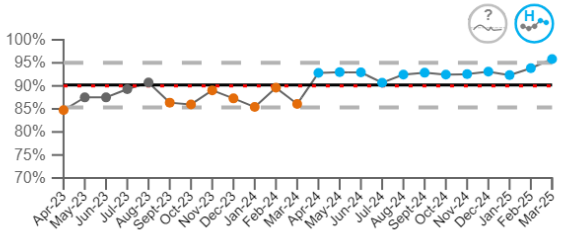
Ref: C02 Performance: 91.0% CNTW Std: 90%



Did you feel safe?

Low (On Track)

Ref: C03 Performance: 95.8% CNTW Std: 90%



Great Place to Work - Headlines

Reporting Period: Mar 2025

Headline Challenges

Sickness Absence
- The confirmed sickness for February 2025 is reported at 6.6% (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.

% of Training Compliance (Courses with a standard), all staff
- In March 2025, Priority Training for All Staff is reported with 9 out of the 11 identified priority training requirements achieving target.
- Local Induction (95% trajectory) and Web Risk Register training (85% trajectory) have not achieved the Q4 trajectory.
- Infection Prevention & Control (IPC) performance has deteriorated over the last 4 months and is reported below the lower control limit.

% of Training Compliance (Courses with a standard, clinical staff)
- 3 of the 9 courses have met the Quarter 4 trajectory.

Appraisals
- Performance has increased to 75.5%, remaining below the Trust 85% target. Without change the target will not be met.

Key focus areas of concern

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

Positive Assurance / Improvement

% of Training Compliance (Courses with a standard, all staff) – 9 out of the 11 identified priority training requirements are achieving target.

% of Training Compliance (Courses with a standard, clinical staff) – 7 out of the 9 identified priority training requirements have had a significant improvement in the year despite only 3 of the 9 being on target.

Clinical Supervision – reported at 81.3% as at 31st March 2025.

Mitigations/actions

Sickness Absence
- The ICB have agreed a target of 1% reduction for all provider organisations by end of 25/26, the start date of the reduction is yet to be defined.
- The CNTW(HR)10 Health Wellbeing and Attendance policy ratified.
- Training for managers on the new policy is underway which has been produced in collaboration with key stakeholders.
- Executive Director Workforce and OD held a focus session with Groups regarding the 1% reduction
- There has been a deep dive session at People Committee in April 2025 on sickness absence.

The current absence mitigations and actions continue:
- Sickness Clinics/Meetings
- Short Term absence continues to be monitored
- Ensuring wellbeing conversations take place
- Work commencing on reviewing reasonable adjustments
- Thrive website and wellbeing offer
- Monthly Health & Wellbeing steering group in place.
- Occupational Health intervention for staff.
- Regional Wellbeing hub in place to support staff referrals.
- Decision to de-commission SPC was made at EMG in March 2025, current plans on how to support are being worked through. All mental health referrals will now be made to the regional wellbeing hub. Process is currently being reviewed to fast track staff who require additional specialist MH support into Trust services.

% of Training Compliance (Courses with a standard, clinical staff)
- Training Group have met to discuss priority training areas for 25/26 with trajectories to be agreed by EMG in April 2025.
- Monitored within weekly Group Safety meetings and Operational Management Groups (OMG).

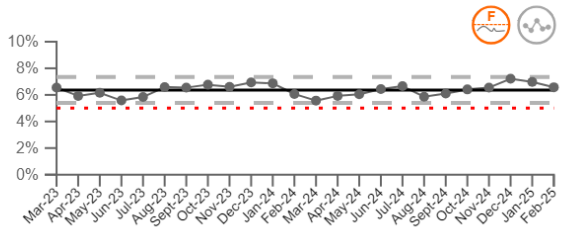
Great Place to Work

Reporting Period: Mar 2025

Sickness in Month

High (Action)

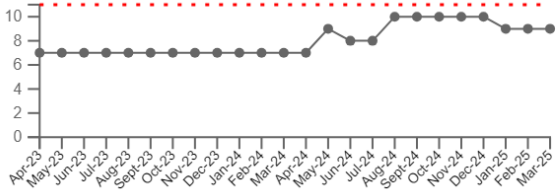
Ref: P01 Performance: 6.6% NHSE Std: 5%



All Staff Priority Training

Low (On Track)

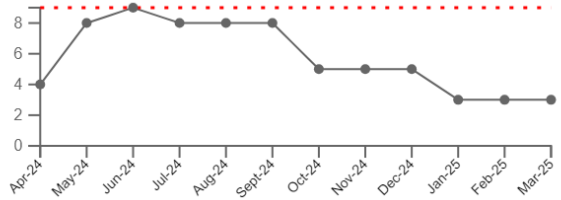
Ref: P02 Performance: 9 CNTW Std: 11



Clinical Staff Priority Training

High (Action)

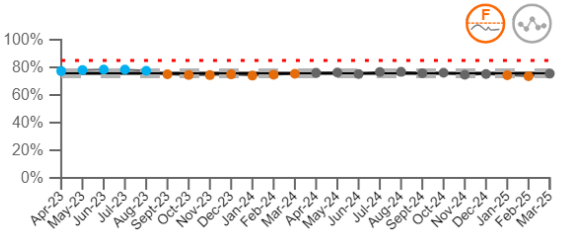
Ref: P03 Performance: 3 CNTW Std: 9



Appraisal rate

High (Action)

Ref: P04 Performance: 75.5% CNTW Std: 85%



Quality Care, Everyday - Headlines

Reporting Period: Mar 2025

Headline Challenges

- **% of Patients with a Risk Management and Personalised Safety Plan -** Metrics continue to be monitored to assure delivery and compliance with quality standards for the new biopsychosocial risk assessments (BPS) framework. There has been a continual improvement month by month since April 2024.
- **Record of Capacity/Consent to Treatment (CTT) at point of detention** – is consistently off target, in March performance decreased now being 32.5% below target, significant improvement across the Trust is required.
- **Rights at Point of Detention** – Decreased in the month reported at 9.1% below target. Without change, performance will remain consistently off target.
- **Long term segregation and prolonged seclusion** – Reported at 14 for March 2025, (13 reported February 2025)
- **Assaults on Patients** – Decreased in the month, 65.5% of the assaults involved no physical harm and 34.5% resulted in low physical harm. There were no reported incidents classed as moderate or severe physical harm.
- **Assaults on Staff** – Increased in the month. 48.6% of the assaults involved no physical harm and 47.6% resulted in low physical harm and 18 (3.8%) classified as moderate physical harm. There were no reported incidents classed as severe physical harm.
- **Reducing Incidents of self-harm –** 98.8% resulted in low or no physical harm, 0.7% (9) moderate physical harm and 0.5% (7) were reported as severe physical harm.

Key focus areas of concern

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

Positive Assurance / Improvement

- **MRE Restraints** – Lowest position reported for 24 months
- **Prone Restraints –** reduced from around 100-120 per month two years ago to less than 32 per month over the last six months. At only 9 now.

Mitigations/actions

- **Staff and Patient Assaults –** Debrief Policy approved and implementation commenced, with updated training and collection of information. Talk 1st dashboard to be updated , so that compliance for both patient and staff debrief can be clearly measured. Financial year end data for both violence and RIDDOR activity will be considered at both Trust-wide Safety Group and the Violence Reduction Group to track progress against plans.
- **Incidents of self-harm -** Following these incidents debriefs occur which can be used to share learning across the care groups. 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. Management of self-harm is individualised, and care planned for each person based on formulation and reviewed as required. Due to the individualisation, management can vary however in some cases observation increase, 1:1 sessions, reflection sessions, facilitating activity / OT activities, graded approach to intervention.

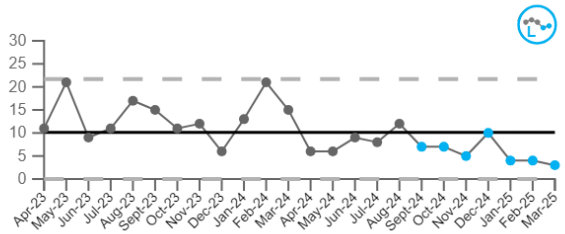
Quality Care, Everyday

Reporting Period: Mar 2025

MRE Restraints

Med (Monitoring)

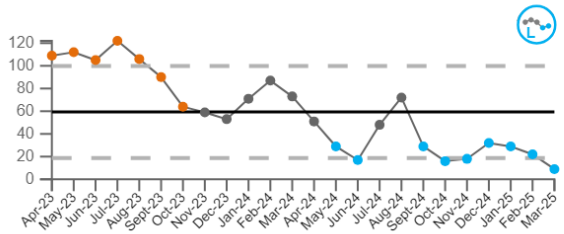
Ref: Q01 Performance: 3 Plan: n/a



Prone Restraints

Med (Monitoring)

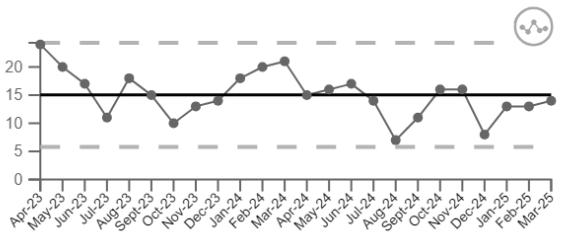
Ref: Q02 Performance: 9 Plan: n/a



Long term segregation and prolonged seclusion

Med (Monitoring)

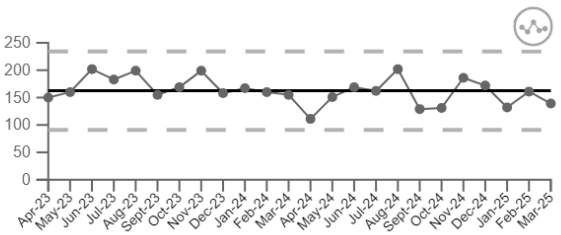
Ref: Q03 Performance: 14 Plan: n/a



Assaults on Patients

Med (Monitoring)

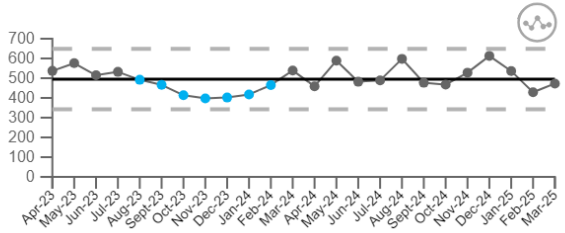
Ref: Q04 Performance: 139 Plan: n/a



Assaults on staff

Med (Monitoring)

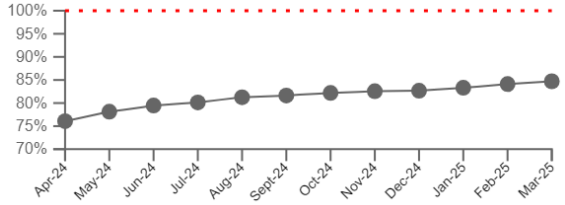
Ref: Q05 Performance: 473 Plan: n/a



% of patients with a Safety Plan

Med (Monitoring)

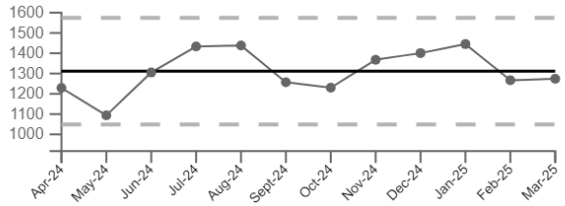
Ref: Q06 Performance: 84.7% CNTW Std: 100%



Reducing incidents of self-harm

Med (Monitoring)

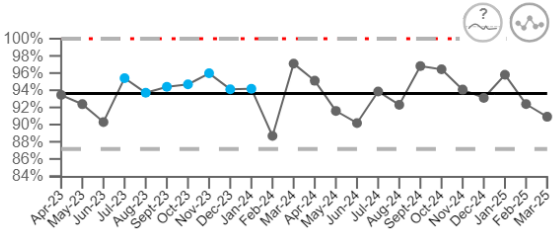
Ref: Q07 Performance: 1,274 Plan: n/a



Rights at Point of Detention

Med (Monitoring)

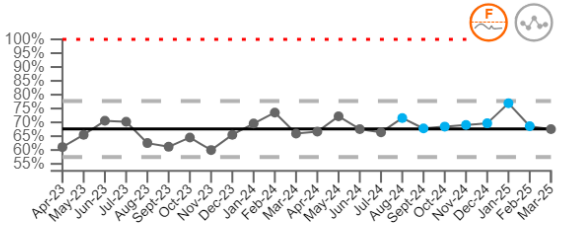
Ref: Q08 Performance: 90.9% CNTW Std: 100%



Record of Capacity/ CTT at point of detention

High (Action)

Ref: Q09 Performance: 67.5% CNTW Std: 100%



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

Reporting Period: Mar 2025

Headline Challenges

- **Bed occupancy –** remains off target at 93.2%.
- **Active Inappropriate Out of Area Placements –** There were ten reported out of area placements active at 31/03/2025.
- **Adult inpatients discharged with LOS >60 days** – Reported at 25.6%, (23 patients discharged with a LOS >60 days in the month).
- **Older Adult inpatients discharged with LOS >90 days** – Reported at 46.0%, (17 patients discharged with a LOS >90 days in the month).
- **Clinically Ready for Discharge** – Remains off target with most of the patients waiting for external packages of care, housing and care home places. 4th month above the upper control limit
- **Crisis Very Urgent Referrals seen within 4 hours –** Performance improved in the month, reported at 54.6% against a trajectory of 80%.
- **Crisis Urgent Referrals seen within 24 hours –** Performance deteriorated in the month, reported at 76.9% in March against an 85% target.
- **Psychiatric Liaison seen within ED within 1 hour -** Performance improved in the month, reported just below target at 79.5%
- **4wks Referral to Treatment - Adult and Older Adult** – 23.5% of referrals have been waiting 4 weeks or less to treatment. The Quarter 4 trajectory of 65% has not been met.
- **4wks to Referral to Receive Help - All CYPS** – 6.6% of referrals have been waiting 4 weeks or less to receive help. The Quarter 4 trajectory of 45% has not been met.

Key focus areas of concern

- **Clinically Ready for Discharge**
- **Crisis Very Urgent Referrals seen within 4 hours**
- **% waiting < 4 weeks to Receive Help – All CYPS**
- **% waiting < 4 weeks to treatment – Adult & Older Adult Services**

Positive Assurance / Improvement

- **Psychiatric Liaison seen within Ward in 24 hours –** Continues to be reported above target
- **EIP Starting treatment in 2 weeks** – Reported consistently above target

Mitigations/actions

Out of Area Placements / Clinically Ready for Discharge– Daily urgent flow escalation meetings are in place within representation from all Care Groups. An action plan has been developed to oversee key interventions. This Includes a focus on the highest impact areas by pathway for CRFD patients, development of a social care model to support patients in rehabilitation wards with social care/residential care needs, reviewing the recent changes to the admission pathway through Acute Hospitals Emergency Departments, and enhance the discharge facilitator teams to support patient pathways. This focus on improving flow will reduce patients who are CRFD and or out of area position by June 2025. *Recovery plan in place*

Crisis Very Urgent and Urgent Referrals – The Trust Innovation Group are supporting improvement work regarding this pathway and the teams are aiming to standardise Crisis pathways across all localities. A new improvement trajectory has been developed for 25/26 to drive improvement. The March 2025 EMG agreed for options to be developed on the section 136 facilities to consolidate the estate and improve the staffing availability across crisis pathways. *Recovery plan in place*

% waiting less than 4-week All CYPS – This measure remains low due to a rise in Neurodevelopmental referrals. To support pathway improvements, the Trust has been working with the ICB as part of an all-age neurodivergence group. The Trust have set improvement goals with the small amount of Service Development Funding (SDF) that has been secured. However, a significant system shift is required to tackle this complex challenge. A review of the adult and CYP Neurodevelopmental waiting times position has been considered by EMG with further work to be progressed with partners.

% waiting < 4 weeks to treatment – Adult & Older Adult Services - Over the past 18 months, the average patient waiting time has improved, supported by strong national benchmarking. However, performance remains below the ambitious target of assessing 65% of individuals within four weeks. To drive further progress, the Access Oversight Group conducts bi-weekly reviews of team performance, ensuring continued improvements in delivery. *Recovery plan in place with trajectories for 25/26.*

Live within our means – Groups have identified specific areas for review to influence financial performance. BDG monthly finance meetings determine actions regarding the in-year financial status of the Trust and forecasted positions.

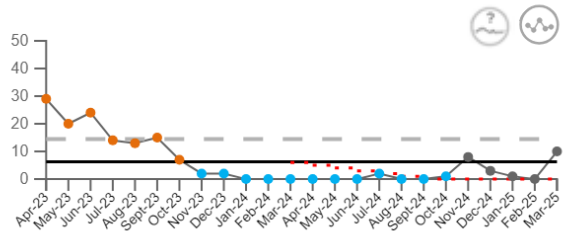
Person Led Care, when and where it's needed

Reporting Period: Mar 2025

Active Inappropriate Out of Area Placements (OAPs)

Med (Monitoring)

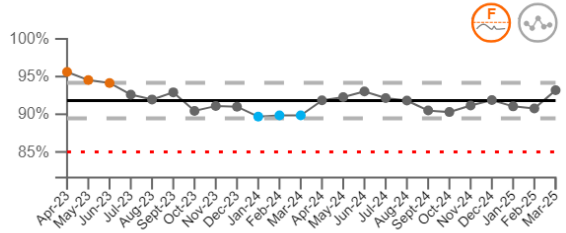
Ref: A01 Performance: 10 NHSE LTP: 0



Bed Occupancy including leave (open beds on RiO)

High (Action)

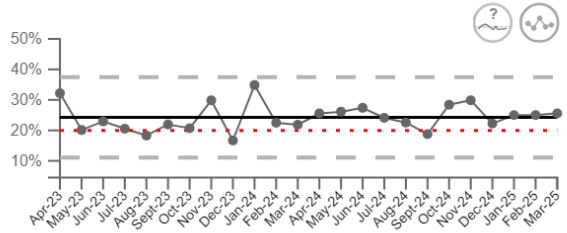
Ref: A02 Performance: 93.2% NHSE Std: 85%



% Adult inpatients discharged with LOS > 60 days

Med (Monitoring)

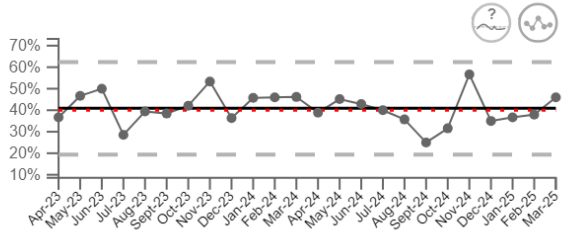
Ref: A03 Performance: 25.6% CNTW Std: 20%



% OP inpatients discharged with LOS > 90 days

Med (Monitoring)

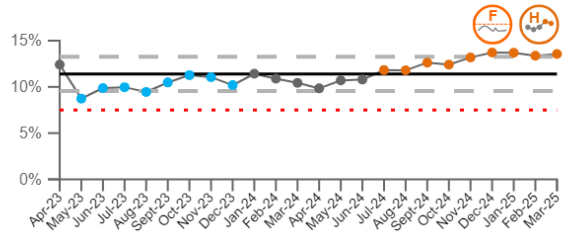
Ref: A04 Performance: 46.0% CNTW Std: 40%



Clinically Ready for Discharge (formerly DTOC)

High (Action)

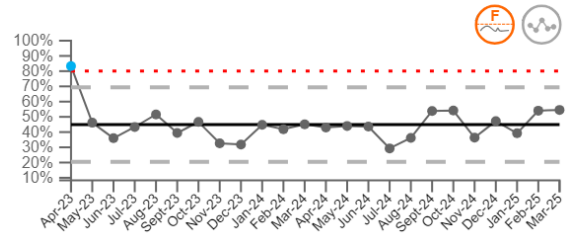
Ref: A05 Performance: 13.6% NHSE Std: 7.5%



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

High (Action)

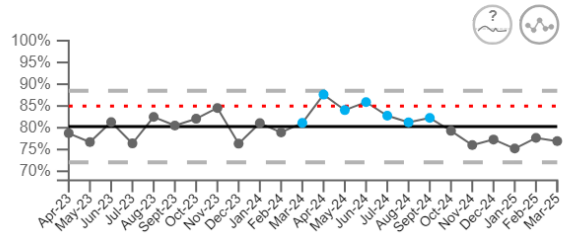
Ref: A06 Performance: 54.6% CNTW Traj: 80%



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

Med (Monitoring)

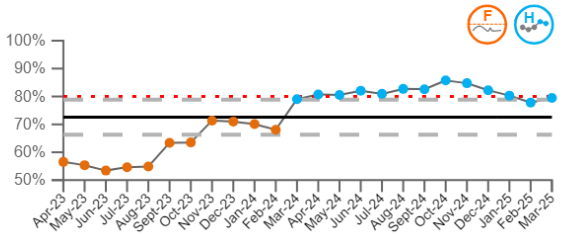
Ref: A07 Performance: 76.9% CNTW Std: 85%



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

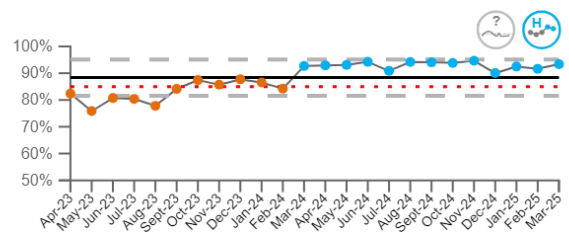
Ref: A08 Performance: 79.5% CNTW Std: 80%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

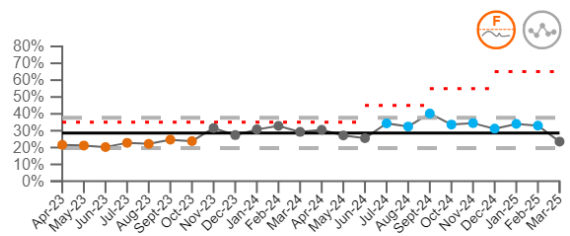
Ref: A09 Performance: 93.4% CNTW Std: 85%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

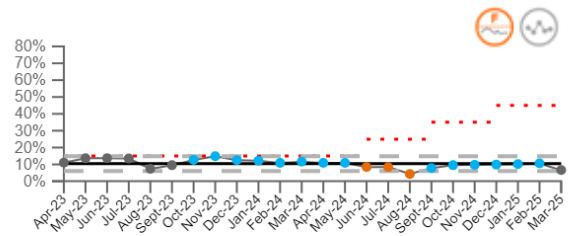
Ref: A10 Performance: 23.5% CNTW Traj: 65%



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

High (Action)

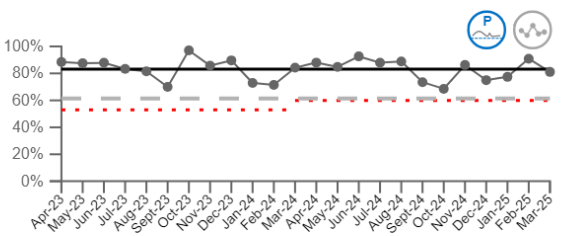
Ref: A11 Performance: 6.6% CNTW Traj: 45%



EIP – starting treatment in 14 days

Low (On Track)

Ref: A12 Performance: 81.1% CNTW Std: 60%



Sustainable for the Long Term - Headlines

Reporting Period: Mar 2025

Headline Challenges

- The trust year end position is a £4.2m surplus. The surplus is £1.8m ahead of the trust revised plan for a £2.4m surplus.
- The Trust surplus is supported by agreed funding from the ICB and NHS England for several specific pressures in 2024/25. and deficit funding. The funding is non-recurrent.
- At the end of March, the Trust has spent £8.8m on agency staff against a plan for £10.8m.
- The Trust is overspending within the Inpatient Group. The overspend is being mitigated by underspends elsewhere in the Trust (Community & Corporate) and one-off benefits.
- Following a review of the Trust and ICB capital programmes, the Trust has reported to breach the CDEL limit by £1.8m. The ICB are aware of the Trust position and underspends elsewhere in the ICB are offsetting the overspend. In 24/25 the Trust has drawn down £8.5m of the £8.9m NHP approved funding for CEDAR from the addendum business case.
- The Trust is holding a cash balance of £43.5m, which is ahead of plan. The Trust has a higher cash balance from receipt of sale proceeds, higher capital draw down than plan and receipt of non-recurrent funding from the ICB.

Key focus areas of concern

- The Trust has completed a review of the delivery of the planned efficiency programme submitted as part of the annual plan. The review shows the Trust will deliver the total planned efficiency, but the split between recurrent and non-recurrent savings will change from 67%/33% to 40%/60%
- The Inpatients group have overspent by £4.8m. This recognises planned developments will not take place in 2024/25 but are expected to deliver across 25/26 and 26/27.
- The Trust workforce plan included a reduction of over 450 wte from April to March. The trust has delivered the financial plan without a reduction in wte used. WTE are planned to reduce by 341 in 2025/26.

Positive Assurance / Improvement

- The agency spend for the year was £8.8m against the plan for agency for £10.8m. The Trust monthly agency spend has been below the agency monthly agency ceiling throughout 2024/25.
- The Trust forecast out-turn has improved following agreeing further deficit support funding and pressure funding,. The Trust as delivered a £4.2m surplus.

Mitigations/actions

- Trust has utilised significant levels of non recurrent benefits to deliver the financial position. This includes transactions that benefit the Income & Expenditure (I&E) position.
- 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 focuses time on plans for longer term financial sustainability. The Trust will agree trajectories for services 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 risk and mitigation analysis is presented.
- Daily staffing reviews taking place across inpatient areas.
- The Trust is forecasting to breach the allocated CDEL limit for capital by £1.8m. This is in agreement with the ICB. This is following reviews of the ICB and Trust capital programmes. The forecast includes drawing down £8.5m of the remining £8.9m funding for CEDAR in 2024/25.
- Weekly meeting to review and maximise the Trust cash balances.

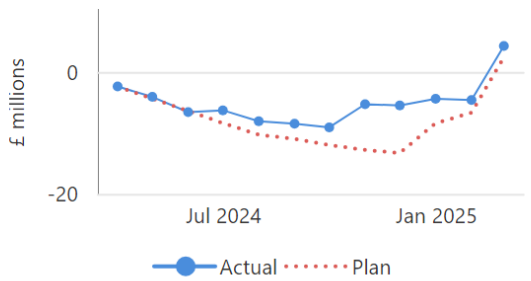
Sustainable for the Long Term

Reporting Period: Mar 2025

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

Low (No Target)

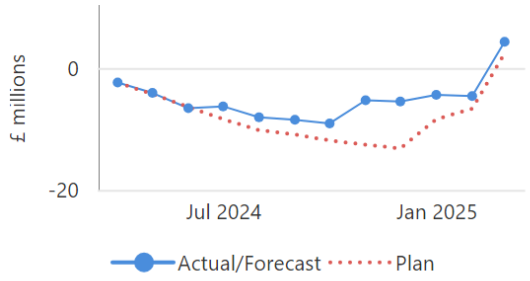
Ref: S01 **Performance: £4.2m** **Plan: £2.4m**



Income & Expenditure Forecast

Low (No Target)

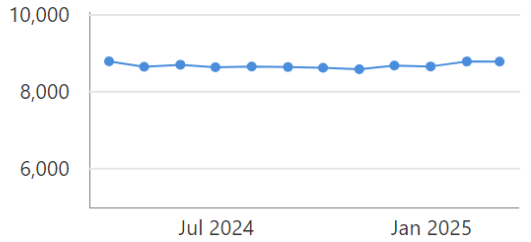
Ref: S02 **Performance: £4.3m** **Plan: £2.4m**



All staff WTEs

Low (No Target)

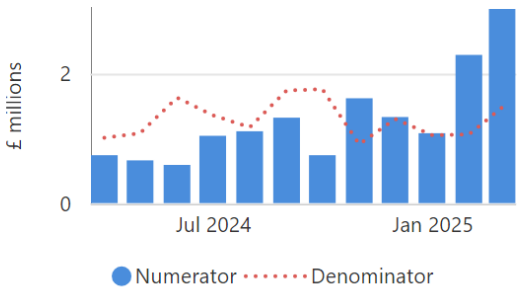
Ref: S03 **Performance: 8,759** **No Target: n/a**



Capital spend compared to plan (£)

Low (No Target)

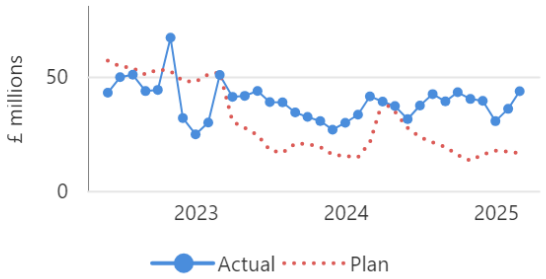
Ref: S04 **Performance: £6.2m** **Plan: £1.5m**



Cash balance compared to plan (£)

Low (On Track)

Ref: S05 **Performance: £43.5m** **Plan: £16.4m**



C01 How was your experience? (FFT)

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

Risk Rating: Med (Monitoring)

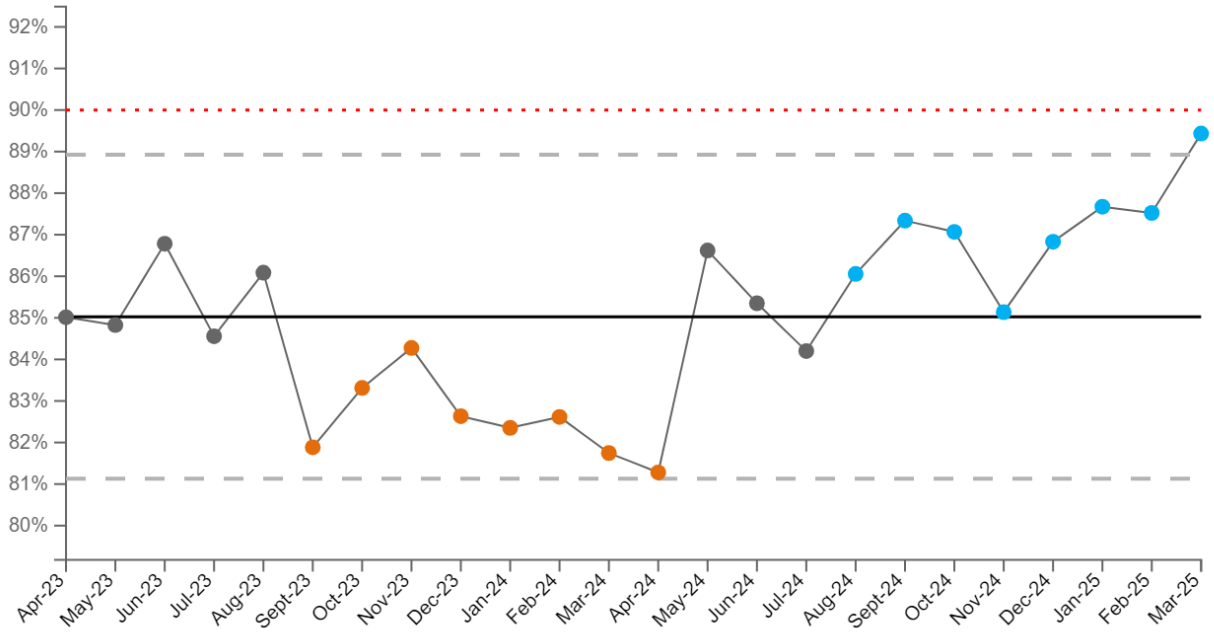
tgt. = target n. = numerator d. = denominator

89.4%	tgt.	90%
	n.	474
	d.	530

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
Community Care Group	89.5%	282	315	90%	SPC n/a	SPC n/a
Inpatient Care Group	87.1%	54	62	90%	SPC n/a	SPC n/a
Specialist Care Group	89.8%	132	147	90%	SPC n/a	SPC n/a
Support & Corporate	100.0%	6	6	90%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Performance was reported at 89.4% for March which is an increase from February (87.5%) and the highest reported performance for 12 months though remaining below the 90% target by 0.6%. Without change, we will remain consistently off target.

Root Cause of the performance issue

- There were 32 (6.0%) negative experiences reported of the 530 responses to this question. This is an improvement from 38 (7.4%) in February 2025.
- There are no teams with high numbers of negative experiences this month.

Improvement Actions

- Completing You Said – We Did posters is a good way of showing how issues are being responded to monthly.
- The Your Voice dashboard is available to staff and support is offered to help staff explore the data and respond to themes as they emerge

Expected impact and by when

The Your Voice experience survey has seen an increase in engagement since it replaced Points of You in April 2024, meaning there are more opportunities at Group, Locality, CBU and team level to respond to experiences of service users and carers and the developing themes more regularly.

C02 How was the care we provided?

How was the care we provided?

Risk Rating: Med (Monitoring)

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

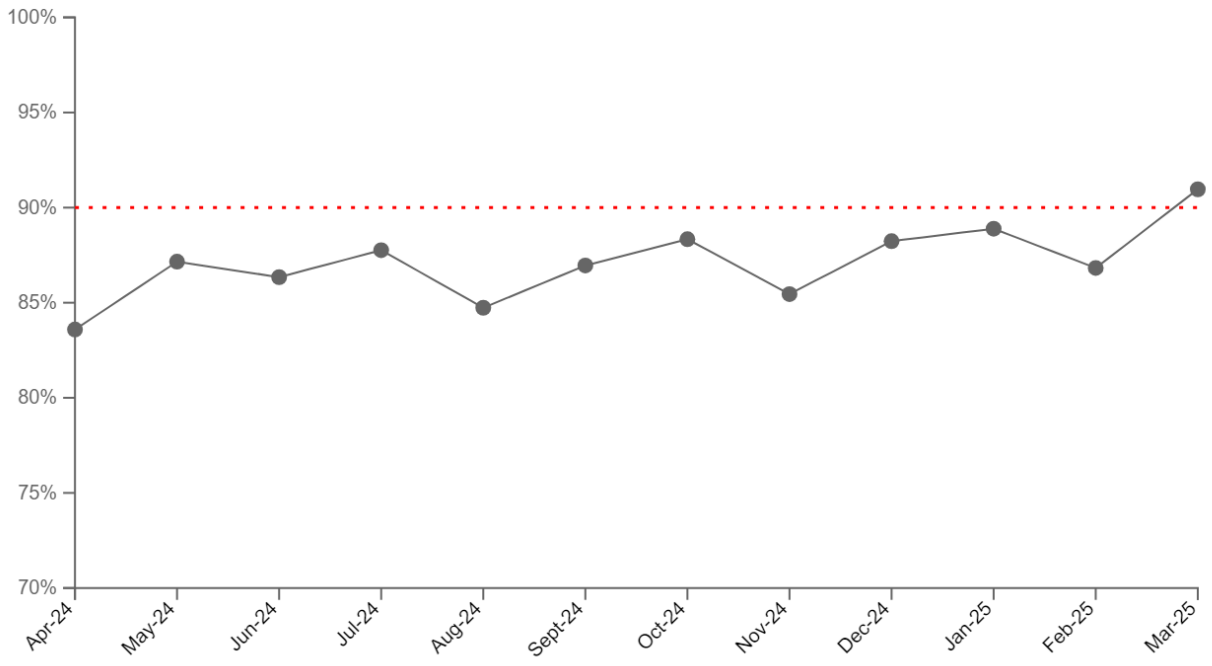
91.0%	tgt.	90%
	n.	463
	d.	509

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	90.3%	269	298	90%	SPC n/a	SPC n/a
Inpatient Care Group	93.4%	57	61	90%	SPC n/a	SPC n/a
Specialist Care Group	91.0%	131	144	90%	SPC n/a	SPC n/a
Support & Corporate	100.0%	6	6	90%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Performance was reported at 91.0% for March, which is an improvement from February (86.8%) and reported above the target for the first time in 12 months.

Root Cause of the performance issue

- 509 people responded to this question, with 463 reporting a good or very good experience of the care provided.
- 27 respondents reported a poor experience (13 very poor and 14 poor) an improvement of 33 in February from 501 responses.
- The 111 service received the highest number of 'Very Poor' responses this month (5)

Improvement Actions

- The Your Voice dashboard is available to staff and support is being offered to help staff explore the data and respond to themes as they emerge.

Expected impact and by when

You Said – We Did posters are a useful way of showing responsiveness, teams should be completing these monthly, making sure they are communicated to service users, carers and staff. March saw 64 posters created (66 in February). Suggesting this isn't embedded as being regularly used as an indicator of responsiveness.

P01 Sickness in Month

Percentage of in month sickness absence

Risk Rating: High (Action)

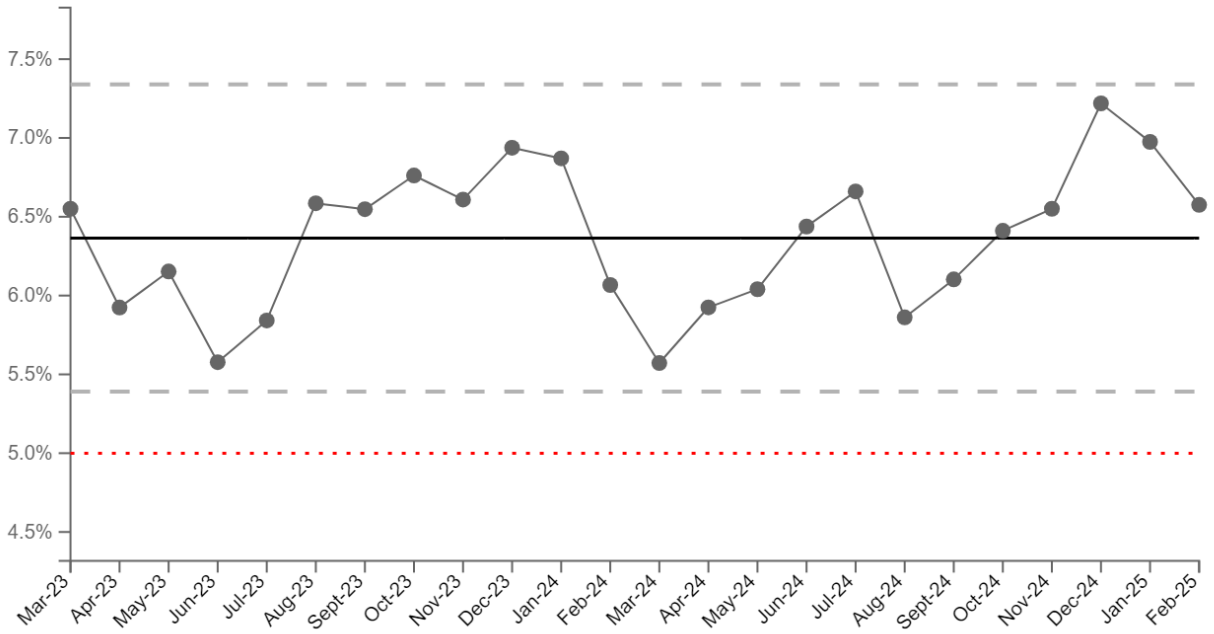
tgt. = target n. = numerator d. = denominator

6.6% tgt. 5% n. 13,696 d. 208,292

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	6.9%	5,816	84,122	5%	Normal Variation	Consistently Off Target
Inpatient Care Group	8.1%	3,826	47,365	5%	Normal Variation	Consistently Off Target
Specialist Care Group	6.2%	3,059	49,650	5%	Normal Variation	Consistently Off Target
Support & Corporate	3.7%	996	27,156	5%	Normal Variation	Consistently Achieve

Feedback

What the chart tells us

The chart shows the confirmed sickness for February 2025 which is reported at 6.6% (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.
- Financial stress impact
- Work-life balance challenges
- Trauma impact working in inpatient services

Improvement Actions continue to be

- Promote and continue to implement the health and wellbeing offer.
- Consider and implement reasonable adjustments and flexibility where possible.
- Robust management of the Optima Health contract.
- Stress at Work policy reviewed
- New Health Wellbeing and attendance policy training underway
- Health and Growth Accelerator Funding announced and support for Regional Wellbeing hub.
- Regional work underway with Executive Director of Workforce & Organisational Development as Senior Responsible Officer
- Deep dive into data and trends
- Sourcing of system to help management of Short-Term sickness

Expected impact and by when

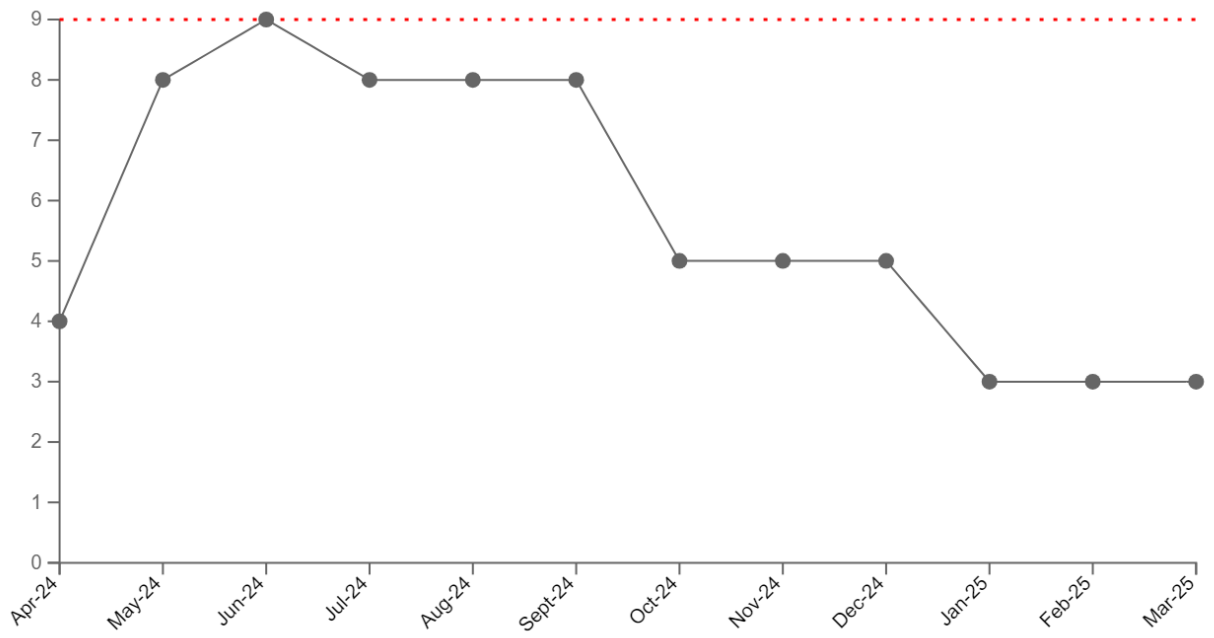
ICB agreed 1% reduction by end of 25/26

P03 Clinical Staff Priority Training

Clinical Staff Priority Training

Risk Rating: High (Action)

3	target	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	Target	Variation	Assurance
Community Care Group	3	7	SPC n/a	SPC n/a
Inpatient Care Group	5	7	SPC n/a	SPC n/a
Other Care Group	1	6	SPC n/a	SPC n/a
Specialist Care Group	4	9	SPC n/a	SPC n/a
Support & Corporate	0	4	SPC n/a	SPC n/a

Feedback

What the chart tells us

Priority Training Compliance for March currently shows 3 out of the 9 identified priority training requirements have achieved the Quarter 4 trajectories. The following courses remain below the 85% trajectory

- Clinical Risk and Suicide Prevention,
- Resuscitation L2 Adult Basic Life Support,
- Resuscitation L3 Adult Immediate Life Support
- Resuscitation L3 Paediatric Immediate Life Support
- Resuscitation L2 Paediatric Basic Life Support
- PMVA Basic

Root Cause of the performance issue

- Capacity to release staff for training
- Late cancellations due to clinical activity

Improvement Actions

- Priority training has been agreed within a Training Performance Framework. Includes 53 Corporate and Operational courses with training standards
- CBU level training trajectory plans established in line with Trust priorities.
- Trajectories to be discussed and approved at EMG (April 25)
- Care Groups monitoring compliance through Operational Management Groups and Safety Meetings.

Expected impact and by when

Increase in training compliance in line with set trajectories by the end of Q2 25/26

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	Normal Variation	Consistently Achieve	91.4%	90%	CNTW Std	8,245	9,025	Low (On Track)
TA02	Corporate Induction	SPC n/a	SPC n/a	95.9%	95%	CNTW Std	8,654	9,025	Low (On Track)
TA03	Local Induction	Improvement	Consistently Off Target	93.9%	95%	CNTW Traj	8,456	9,009	Med (Monitoring)
TA04	Safeguarding Adults Level 1	Normal Variation	Consistently Achieve	95.6%	85%	CNTW Std	1,620	1,695	Low (On Track)
TA05	Safeguarding Children Level 1	Normal Variation	Consistently Achieve	95.2%	85%	CNTW Std	1,614	1,695	Low (On Track)
TA06	Fire	Improvement	Consistently Achieve	89.7%	85%	CNTW Std	8,097	9,025	Low (On Track)
TA07	Equality & Diversity Introduction	Improvement	Consistently Achieve	95.5%	85%	CNTW Std	8,618	9,025	Low (On Track)
TA08	Health & Safety	Improvement	Consistently Achieve	95.0%	85%	CNTW Std	8,570	9,025	Low (On Track)
TA09	Infection Prevention & Control (IPC)	Concern	Consistently Achieve	93.1%	85%	CNTW Std	8,398	9,025	Med (Monitoring)
TA10	Moving & Handling Awareness Training	Improvement	Consistently Achieve	93.9%	85%	CNTW Std	8,471	9,025	Low (On Track)
TA11	Web Risk Register	SPC n/a	SPC n/a	63.0%	85%	CNTW Traj	1,411	2,239	High (Action)

Clinical Staff Priority Training

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TC01	Clinical Risk and Suicide Prevention	Normal Variation	Achieve at Random	83.4%	85%	CNTW Traj	3,339	4,006	Med (Monitoring)
TC02	Biopsychosocial at Risk Assessment & Safety Planning	SPC n/a	SPC n/a	89.9%	85%	CNTW Traj	3,601	4,006	Low (On Track)
TC03	Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	Improvement	Consistently Off Target	77.3%	85%	CNTW Traj	1,433	1,854	High (Action)
TC04	Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	Improvement	Consistently Off Target	74.8%	85%	CNTW Traj	2,547	3,404	High (Action)
TC05	Resuscitation - Level 3 - Paediatric Immediate Life Support - 1 Year	Improvement	Consistently Off Target	42.5%	85%	CNTW Traj	17	40	High (Action)
TC06	Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	Improvement	Consistently Off Target	76.2%	85%	CNTW Traj	451	592	High (Action)
TC07	PMVA Basic	Improvement	Consistently Off Target	81.4%	85%	CNTW Traj	2,086	2,563	Med (Monitoring)
TC09	Engagement & Observation	Improvement	Achieve at Random	88.1%	85%	CNTW Traj	2,784	3,159	Low (On Track)
TC10	Dysphagia Awareness	Improvement	Consistently Achieve	87.4%	75%	CNTW Traj	2,252	2,577	Low (On Track)

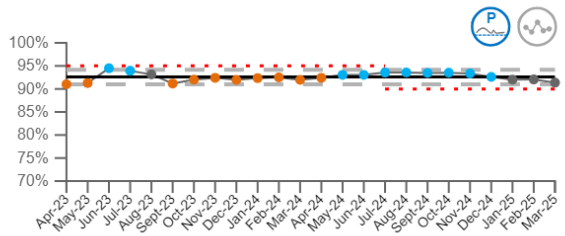
All Staff Priority Training

Reporting Period: Mar 2025

Information Governance

Low (On Track)

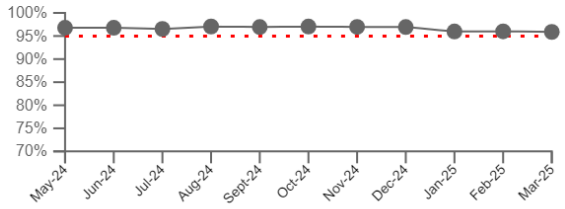
Ref: TA01 Performance: 91.4% CNTW Std: 90%



Corporate Induction

Low (On Track)

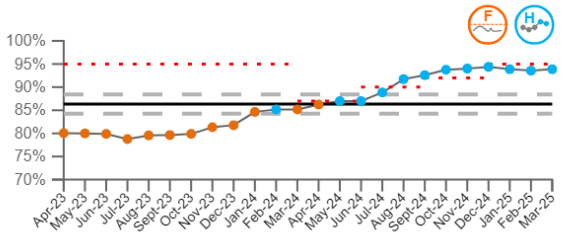
Ref: TA02 Performance: 95.9% CNTW Std: 95%



Local Induction

Med (Monitoring)

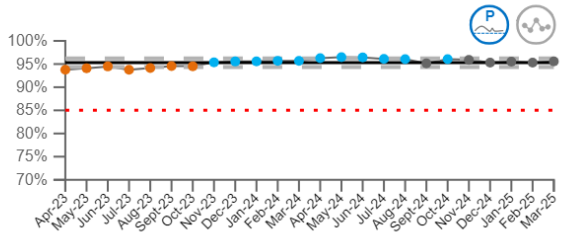
Ref: TA03 Performance: 93.9% CNTW Traj: 95%



Safeguarding Adults Level 1

Low (On Track)

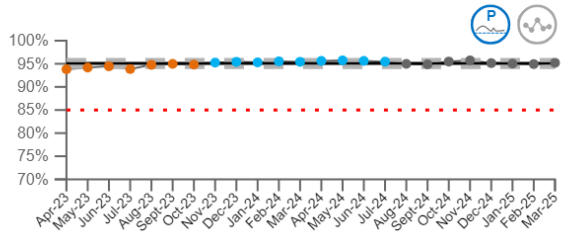
Ref: TA04 Performance: 95.6% CNTW Std: 85%



Safeguarding Children Level 1

Low (On Track)

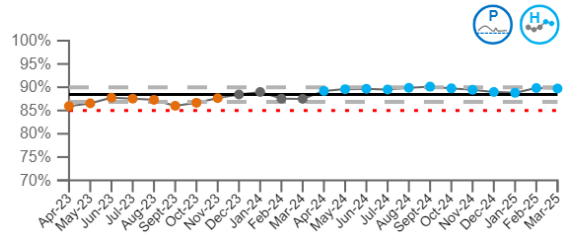
Ref: TA05 Performance: 95.2% CNTW Std: 85%



Fire

Low (On Track)

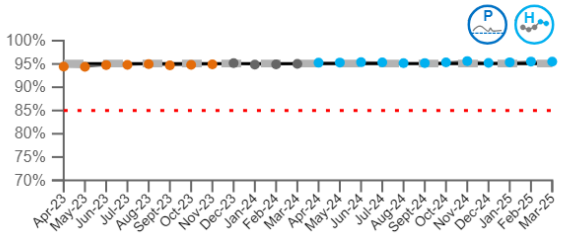
Ref: TA06 Performance: 89.7% CNTW Std: 85%



Equality & Diversity Introduction

Low (On Track)

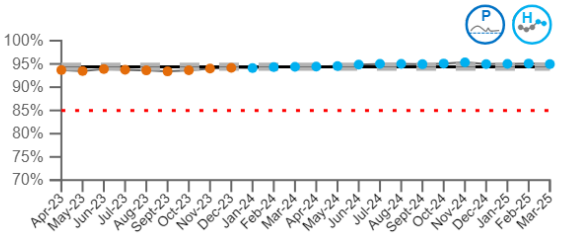
Ref: TA07 Performance: 95.5% CNTW Std: 85%



Health & Safety

Low (On Track)

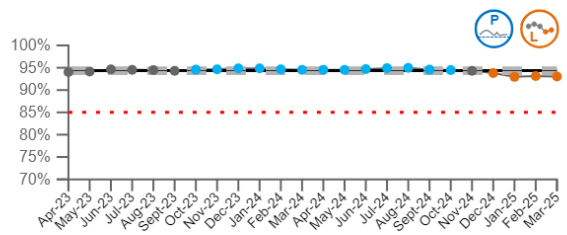
Ref: TA08 Performance: 95.0% CNTW Std: 85%



Infection Prevention & Control (IPC)

Med (Monitoring)

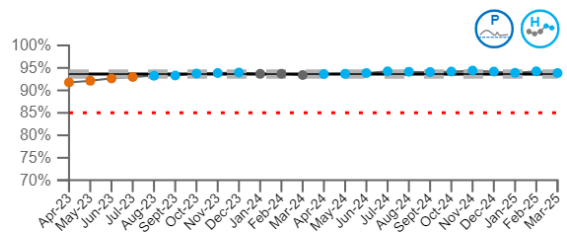
Ref: TA09 Performance: 93.1% CNTW Std: 85%



Moving & Handling Awareness Training

Low (On Track)

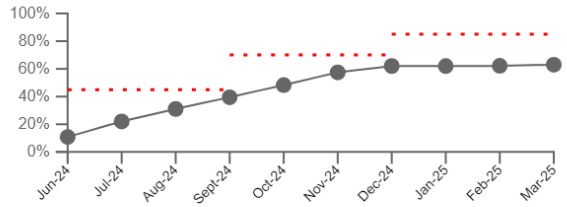
Ref: TA10 Performance: 93.9% CNTW Std: 85%



Web Risk Register

High (Action)

Ref: TA11 Performance: 63.0% CNTW Traj: 85%



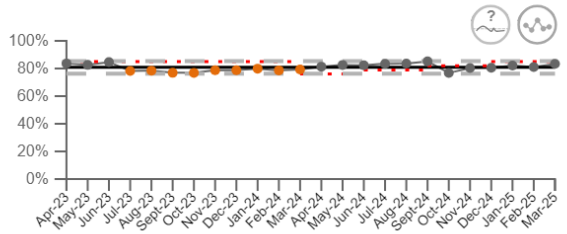
Clinical Staff Priority Training

Reporting Period: Mar 2025

Clinical Risk and Suicide Prevention

Med (Monitoring)

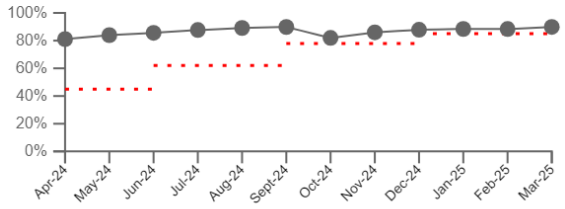
Ref: TC01 Performance: 83.4% CNTW Traj: 85%



Biopsychosocial at Risk Assess. & Safety Planning

Low (On Track)

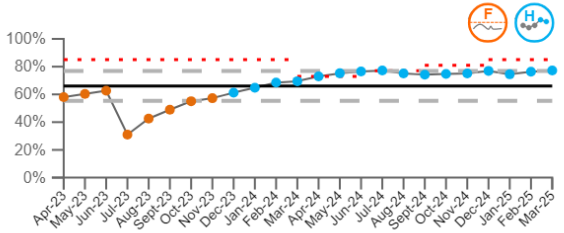
Ref: TC02 Performance: 89.9% CNTW Traj: 85%



Resuscitation L2 Adult Basic Life Support

High (Action)

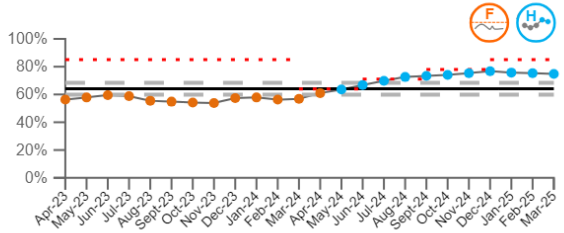
Ref: TC03 Performance: 77.3% CNTW Traj: 85%



Resuscitation L3 Adult Immediate Life Support

High (Action)

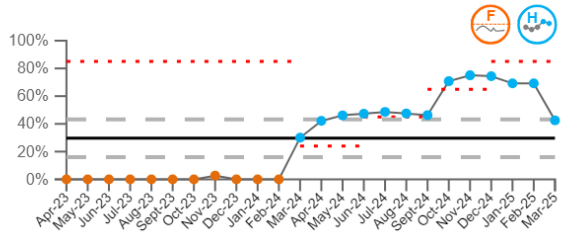
Ref: TC04 Performance: 74.8% CNTW Traj: 85%



Resuscitation L3 Paediatric Immed Life Support

High (Action)

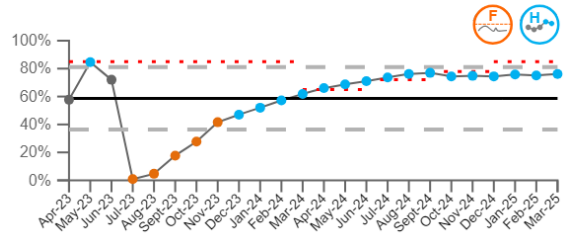
Ref: TC05 Performance: 42.5% CNTW Traj: 85%



Resuscitation L2 Paediatric Basic Life Support

High (Action)

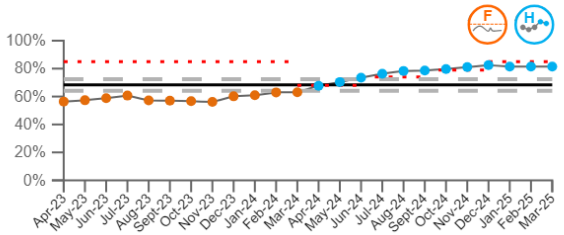
Ref: TC06 Performance: 76.2% CNTW Traj: 85%



PMVA Basic

Med (Monitoring)

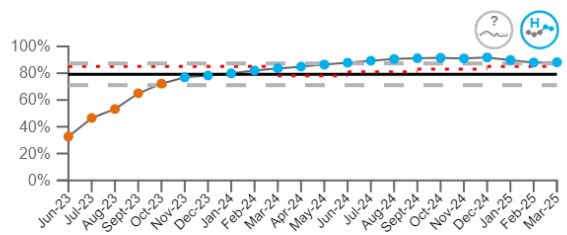
Ref: TC07 Performance: 81.4% CNTW Traj: 85%



Engagement & Observation

Low (On Track)

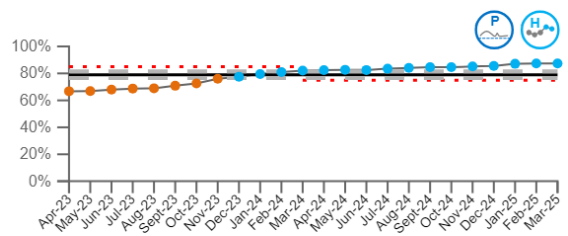
Ref: TC09 Performance: 88.1% CNTW Traj: 85%



Dysphagia Awareness

Low (On Track)

Ref: TC10 Performance: 87.4% 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

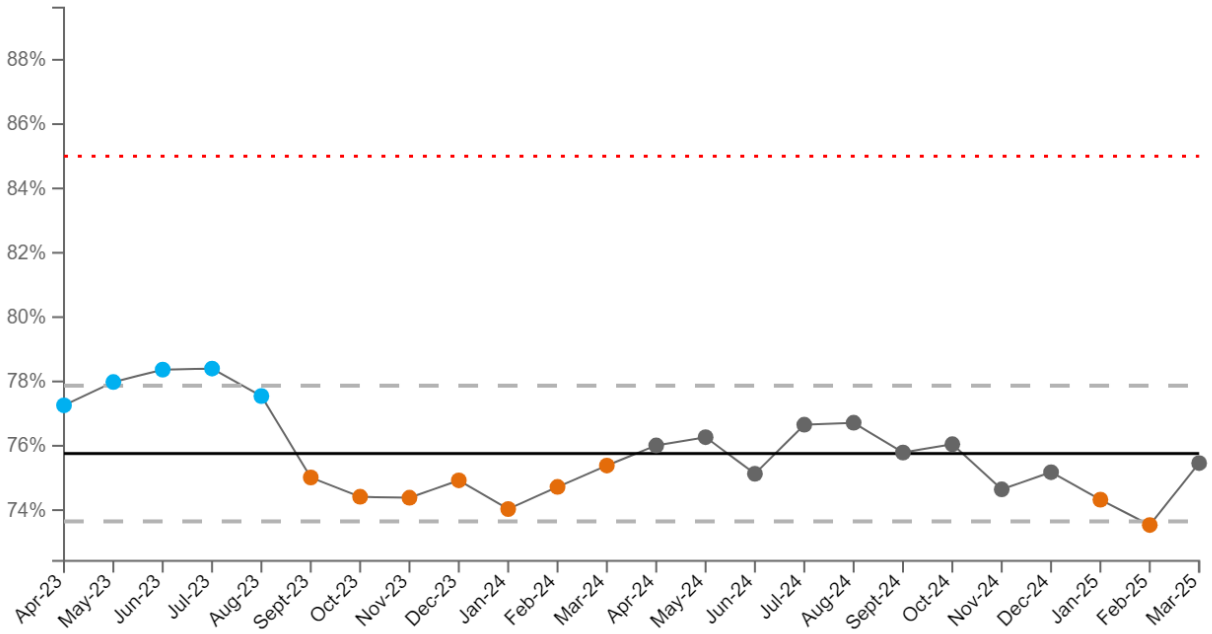
75.5%

tgt. 85%
n. 6,228
d. 8,253

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	78.8%	2,656	3,371	85%	Normal Variation	Consistently Off Target
Inpatient Care Group	75.7%	1,357	1,793	85%	Normal Variation	Consistently Off Target
Specialist Care Group	74.5%	1,441	1,935	85%	Normal Variation	Consistently Off Target
Support & Corporate	67.1%	774	1,154	85%	Concern	Consistently Off Target

Feedback

What the chart tells us

The reported appraisal rate for March is 75.5% which is an increase from February (73.5%)(excluding NTW Solutions), continuing to be reported 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
- Staff survey feedback shows not many staff find value in appraisals

Improvement Actions

- Detailed information provided at Business Development Group – Workforce (BDGW) regarding appraisal rates
- Groups to review those under 50% compliance and provide plans for improvement into BDGW in May 2025

Expected impact and by when

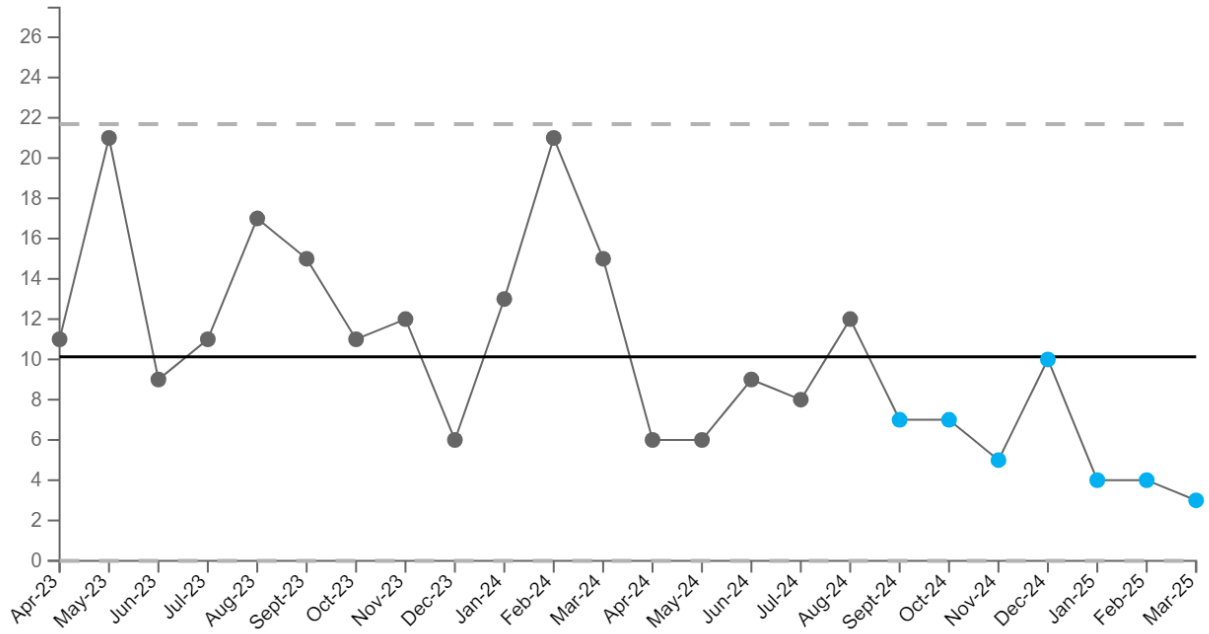
- Appraisal compliance is expected to increase over 2025/26 in line with improvement plans.

Q01 MRE Restraints

Number of MRE Restraints

Risk Rating: Med (Monitoring)

3	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	0	n/a		Normal Variation	SPC n/a
Inpatient Care Group	1	n/a		Normal Variation	SPC n/a
Specialist Care Group	2	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 3 MRE restraints relating to 2 individuals, reported in March 2025. Within Mitford 1 patient accounted for 2 of the incidents and 1 patient on Shoredrift accounted for 1 incident.

Root Cause of the performance issue

- The necessity for moving complex patients for external appointments. Some under the direction of the Ministry of Justice – for example use of handcuffs if escorting. This is a MoJ requirement.
- The one incident reported within the inpatient care group in March was a planned intervention to support a transfer to the local Acute Trust.

Improvement Actions

- Use of MRE reviewed at Early Learning Reviews (ELR), discussed within weekly safety meeting.
- Robust de-brief process to support learning from incidents and review of care plans.
- Talk 1st training has commenced within induction and is also now within the Healthcare Support Worker Certificate (HCSW) programme
- The acute and PICU wards have action plans in place to support achieving the target of 12% of the staff trained in MRE. Where wards have not achieved the 12%, a wider staff cohort (from other wards) are trained to support the delivery of safe use of MRE.
- Inpatient Care Group Reducing Restrictive Interventions (RRI)meeting, and pathway subgroups continue to monitor action plans to support the delivery of the Group's reducing restrictive intervention ambitions.
- The group are revising their RRI ambitions in the context of the understanding gained from six-months of focused work.
- Focus on HOPEs awareness training.
- Reduction of restrictive intervention ambitions and associated timelines agreed with a pathway model approach. Pathway specific workshops commenced in October 2024 which identified key deliverables to ensure delivery of ambition timescales.
- Build in review process for each use with the approving Director.
- Introduction of EMDT commencing on acute wards (from Q1 25/26). This will enhance the input across a range of disciples, therefore augmenting the supportive measure to prevent incidents and increases positive risk taking.

Expected impact and by when

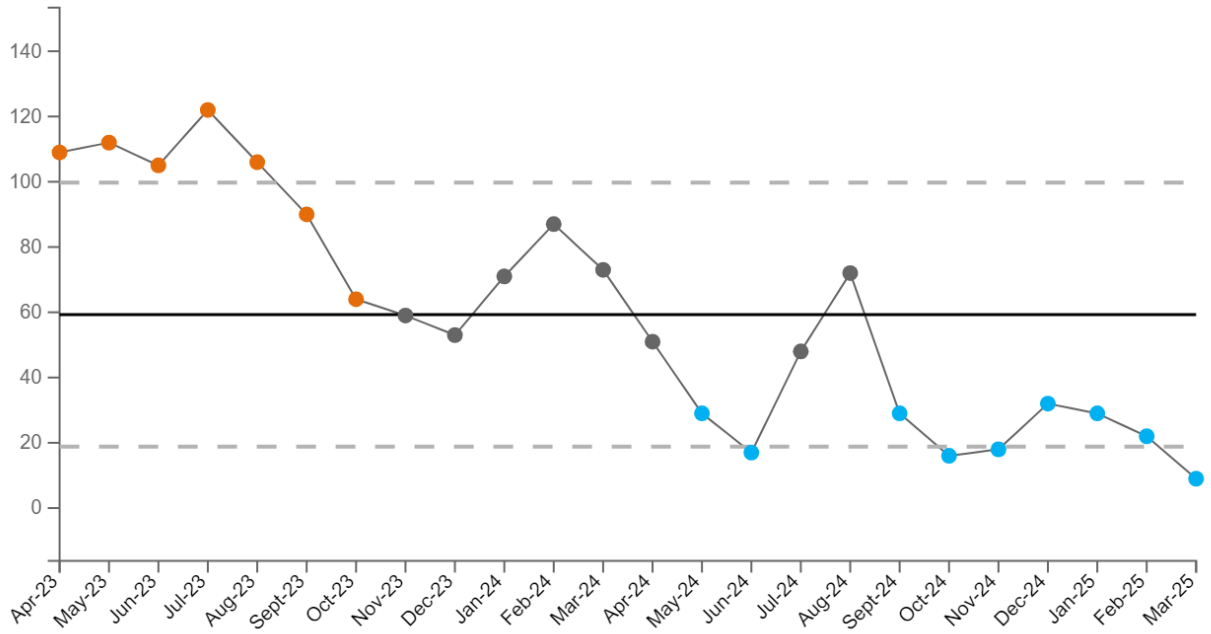
Continued reduction throughout 25/26, further specific actions within Care Groups will support reductions.

Q02 Prone Restraints

Number of Prone Restraints

Risk Rating: Med (Monitoring)

9	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	0	n/a	Improvement	SPC n/a
Inpatient Care Group	3	n/a	Normal Variation	SPC n/a
Specialist Care Group	6	n/a	Improvement	SPC n/a
Support & Corporate	0	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There have been 9 Prone restraints related to 7 individuals, which is a decrease from 22 incidents reported in February. Two separate wards (Mitford (5) and Fraser (1) accounted for 66.7% (6) of the incidents and 33.3% (3) within the inpatient care group It should also be noted that Central and North Cumbria wards have reported no episodes of prone restraint.

Root Cause of the performance issue

- Within Mitford the use of prone decreased to 5 this month (from 12 last month) The uses of prone related to patients and was used to manage risks to staff and levels of aggression. This was usually in the context of other less restrictive techniques not being effective, or where required due to seclusion exit techniques or space constraints. It is noted that staff have moved patients into supine or other less restrictive position when safe to do so. Some patients also move to prone (by self).
- Low levels of prone usage in month with 3 incidents (all in the urgent care pathway) mainly related to supporting medication administration. PICU (Beckfield) continues to report the highest number of prone restraint incidents YTD.
- **Improvement Actions**
- For Mitford all restrictive interventions have senior review and oversight by managers signing off incident forms, safety huddles and clinical reviews, as part of CQC action plan.
- Review the use of safety pods to understand any differences in practice
- Safeguarding plans/care planning in place (CYPS)
- Escalate all episode of prone to debrief that includes senior clinicals and senior leadership (inform care planning and earlier non-restrictive interventions).
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- Focus on HOPEs awareness training
- Increased emphasis on safer alternatives to prone restraint have been maintained across both the Positive and Safe Team and PMVA tutors.
- Inpatient Care Group RRI meeting, and pathway subgroups monitor action plans to support improvement
- The group are revising their RRI ambitions in the context of the understanding gained from six-months of focused work.
- CBU local RRI meetings consider alternative strategies to reduce incidents.
- Emerging themes have been identified where prone is take place, and alternative methods considered.
- Safety Pods are the first consideration should restraint be necessary (after primary and secondary interventions have been exhausted).
- All patient who are known to require restrictive interventions including restraint have trauma informed and individualised care plans in place for this.
- Introduction of EMDT commencing on acute wards (from Q1 25/26). This will enhance the input across a range of disciples, therefore augmenting the supportive measure to prevent incidents and increases positive risk taking.

Expected impact and by when

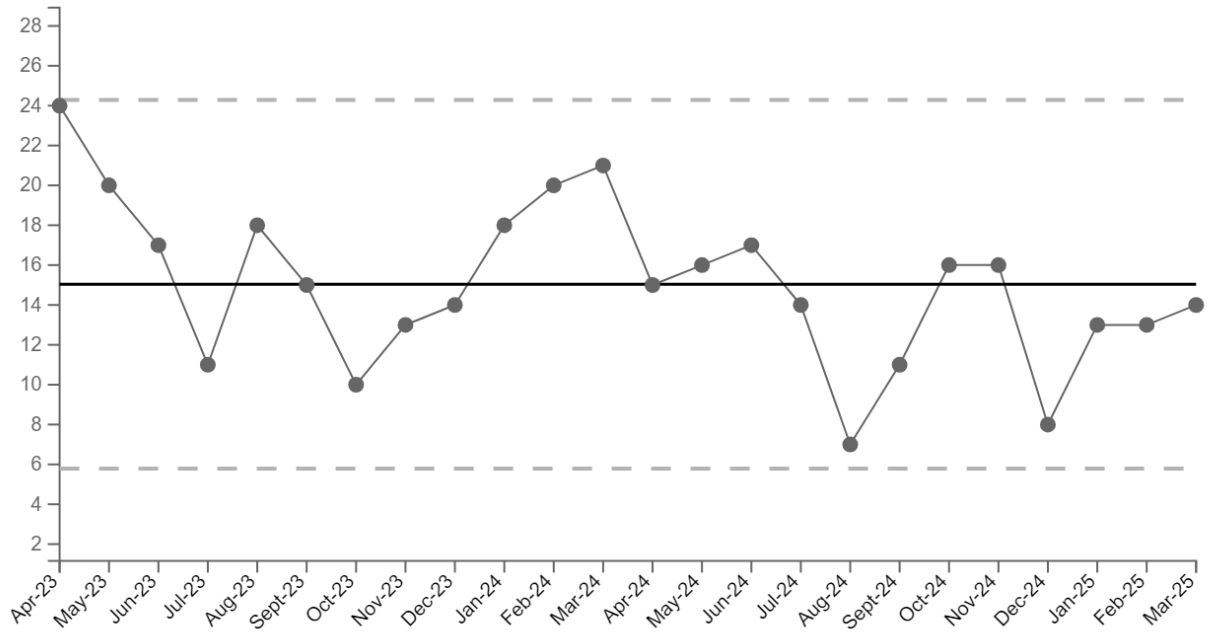
Continued reduction within yearly projections

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
Community Care Group	0	n/a		Normal Variation	SPC n/a
Inpatient Care Group	13	n/a		Normal Variation	SPC n/a
Specialist Care Group	1	n/a		Improvement	SPC n/a
Support & Corporate	0	n/a		Normal Variation	SPC n/a

Feedback

What the chart tells us

There were 14 incidents relating to 14 patients reported in March 2025

Root Cause of the performance issue

- Intensive packages of care required to move patients from seclusion and segregation.
- LTS is in line with individualised care planning and current level of needs within the Specialist Care Group.

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 prolonged seclusion on a weekly basis.
- Long Term Segregation and Prolonged seclusion panel to review and consider all alternatives.
- A full day workshop to identify improvements to the LTS panel was undertaken in March and the results from the day will inform changes to the panels work.
- The Care Groups continue to contribute and attend LTS panels
- LTS will be reviewed at the Reducing Restrictive Interventions meeting, as well as the Inpatient Group's Safety meeting, where individuals care plans and approaches will be considered.
- Approval for commencing and continuing LTS is always considered and approved by an appropriate Director.
- Beckfield has seen the highest reported use of seclusion in the past 2 months. As part of the wards culture of care project Beckfield are making improvements to the seclusion area as well as the de-escalation rooms and chill out room/sensory space. This is a co-produced project with the ward MDT, staff and external subject experts.
- Focus on HOPEs awareness training to support patients to reintegrate into ward environment.
- Mitford reports the CQC action plan. Seclusion has decreased since January and the overall downward trajectory continues. Use of seclusion in February relates to 3 patients on Mitford. Duration ranges from 9-21 hours with an average of 16.4 hours which is an increase from previous months. The understanding of this is that most seclusions occurred in the evening, increasing the likelihood of the patient remaining in seclusion overnight as ending a period of seclusion in line with patients' daily routine is preferred
- The Group are involved in discussions in relation to the appropriate number of seclusion facilities across inpatient sites.

Expected impact and by when

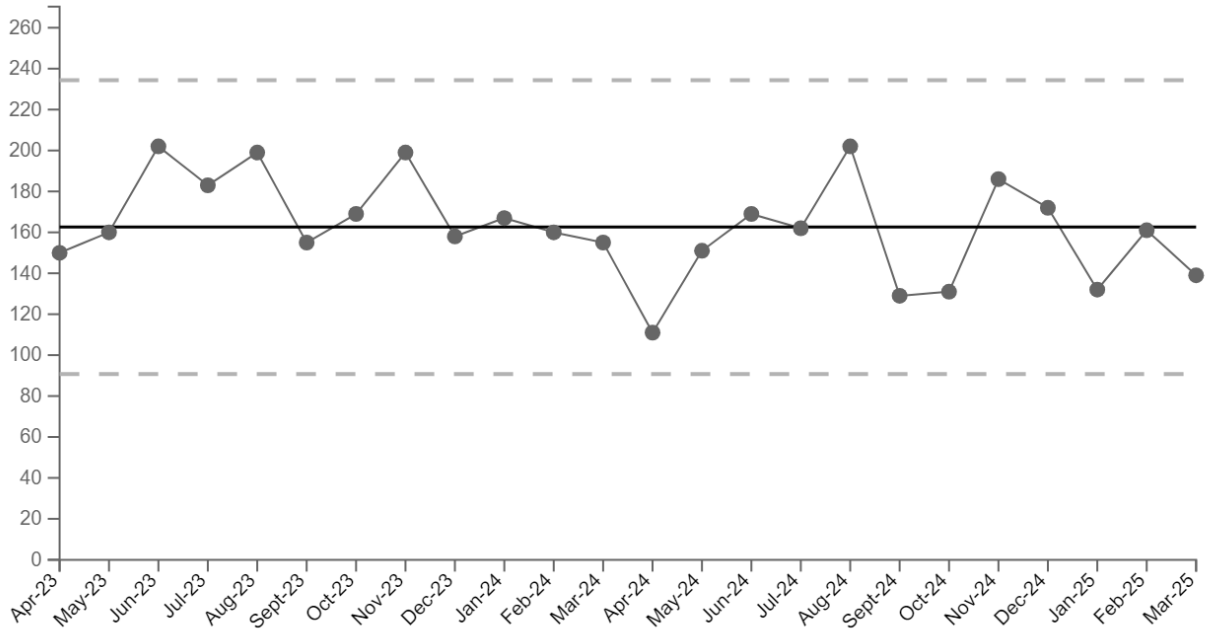
The system blocks remain outside CNTWs control therefore the Trust is dependent upon availability of specialised placements being made available/ built for those patients who require these placements.

Q04 Assaults on Patients

Number of Assaults on Patients

Risk Rating: Med (Monitoring)

139	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	16	n/a	Normal Variation	SPC n/a
Inpatient Care Group	101	n/a	Normal Variation	SPC n/a
Specialist Care Group	22	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 139 recorded incidents of assaults on patients during March.

Root Cause of the performance issue

- Of the 139 assaults in March 2025, 65.5% of the assaults involved no physical harm and 34.5% resulted in low physical harm. There were no assaults recorded as moderate or severe physical harm.
- Studying the assaults on patient data the greater reporting services for patient assaults are as follows; Ruskin, Woodhorn from Older Peoples Services together with Longview, Hadrian and Shoredrift from Adult Acute Services.
- The levels of patient-on-patient assaults continue to be higher in the urgent care pathway (59% of the activity in March). However, when comparing incidents based on bed numbers, proportionally the levels within our older people's pathway is marginally higher than the urgent care pathway. Within each pathway, there is one ward which has reported a greater number of incidents, Beckfield the trust PICU, and Ruskin an organic ward. Although patient assaults within the older people's wards tend to less severe in nature, they still require a review from the clinical team. All incidents in month were either no or low harm.

Improvement Actions

- The new Debrief Policy being implemented will allow a full evaluation of the new debrief form for patients, and this will be monitored by the Debrief task and finish group, with a review of all data across in-patient and community services.
- Further updates have been circulated in a CAS alert so that people are sighted on the policy, standards and training that is available.
- Focus on Safety Huddles across the wards.
- Introduction of EMDT commencing on acute wards (from Q1 25/26). This will enhance the input across a range of disciples, therefore augmenting the supportive measure to prevent incidents and increases positive risk taking.
- As part of the Group RRI meetings, violence and aggression will be an area of discussions including precursors and aligned to the outputs of the Trustwide Violence and Aggression Group.
- Patient on patient assaults remains an area of focus as part of the Reducing Restrictive Interventions and Violence work.
- Mitford; part of CQC action plan and reviewed post incident and audited. A full table is available for overview of all assaults
- Introduction of EMDT commencing on acute wards (from Q1 25/26). This will enhance the input across a range of disciples, therefore augmenting the supportive measure to prevent incidents and increases positive risk taking.

Expected impact and by when

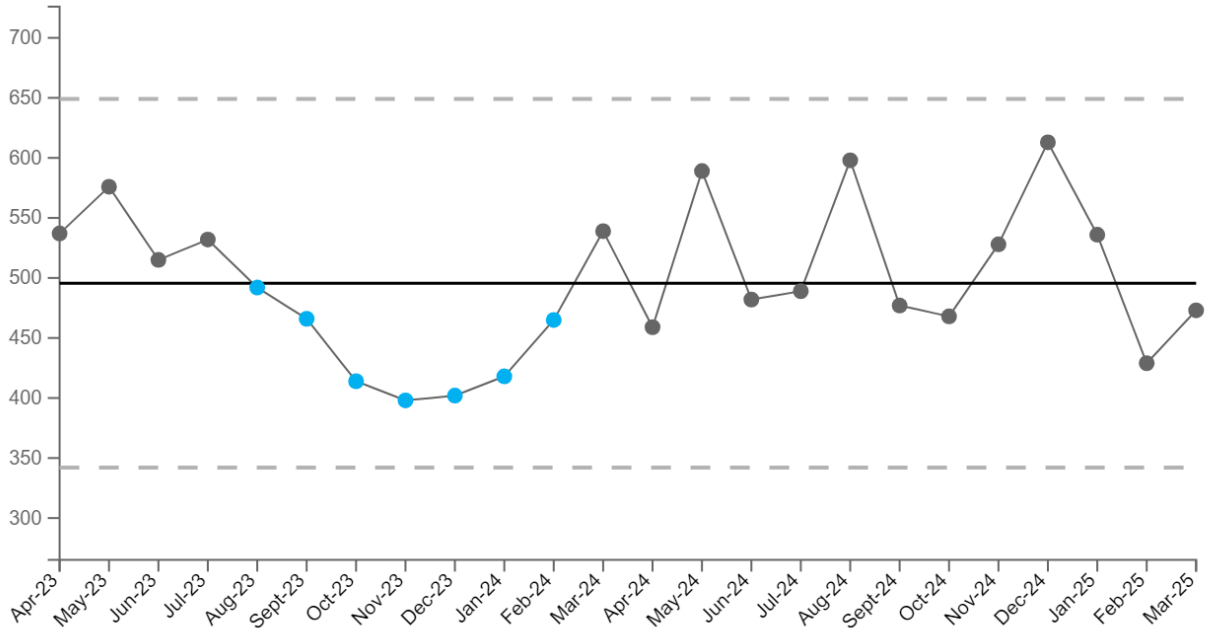
A review is underway in relation to the 25/26 quality priorities with a key focus on further plans for violence reduction across services.

Q05 Assaults on staff

Number of Assaults on staff

Risk Rating: Med (Monitoring)

473	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	13	n/a	Normal Variation	SPC n/a
Inpatient Care Group	244	n/a	Normal Variation	SPC n/a
Specialist Care Group	216	n/a	Normal Variation	SPC n/a
Support & Corporate	0	n/a	Improvement	SPC n/a

Feedback

What the chart tells us

There were 473 recorded incidents of assaults on staff during March which falls within the calculated expected range of 342 and 649 based on assaults on staff incidents recorded across the last 24 months.

Root Cause of the performance issue.

- Assaults on staff have increased from the previous month by 44.
- Of the 473 assaults, 48.6% of the harm was reported as no harm, 47.6% are low harm this is comparable with the previous month with an increase of 2.7% in no harm incidents and a decrease of 3.7% in low harm incidents.
- RIDDOR incidents for the month were reported as 5 in comparison to 4 for February, but a significant drop from the previous 2 months and the lowest since August 2024.
- Ruskin accounted for 3 of RIDDOR incidents for the first time, with 2 of the incidents created by the same patient.

Improvement Actions

- An end of year review in relation to moderate harm incidents and 24/25 RIDDOR activity will be presented to Trust wide Safety Group at end of April.
- Actively engaged in the NHSE Culture of Care Programme, with Rose Lodge an identified pilot ward. As part of this Rose Lodge are currently relaunching the 10 Safewards interventions with a focus on positive words. The culture of care work will enable us to compare with similar organisations.
- Continue to support staff in relation to debriefs. Debrief train the trainer sessions are taking place. The Debrief Policy has been approved and is being implemented.
- Staff side 'drop ins' and increased support and supervision offers to staff where needed.
- Risk assessments in place around violence and aggression in hotspot wards per policy.
- Introduction of EMDT commencing on acute wards (from Q1 25/26). This will enhance the input across a range of disciples, therefore augmenting the supportive measure to prevent incidents and increases positive risk taking.

Expected impact and by when

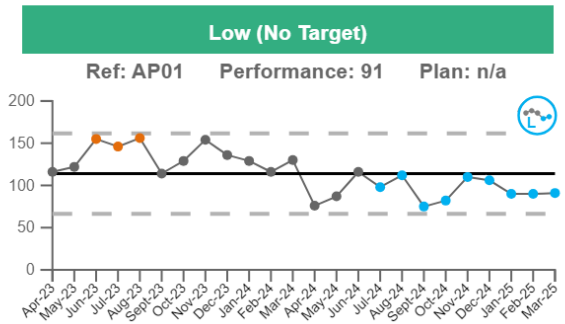
A response is awaited from the HSE around closure of the improvement notice, at the violence reduction group in April the 2nd draft of the Violence Reduction Standards Risk Assessment was received which should focus the actions of the group going forward, this is timely given national announcements about further violence reduction plans by the Health Secretary

Assaults - Type of Harm

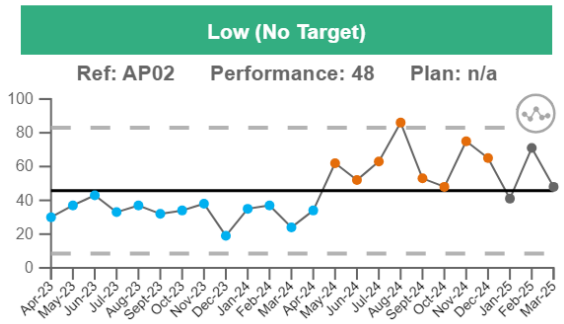
Reporting Period: Mar 2025

Assaults on Patients - Type of Harm

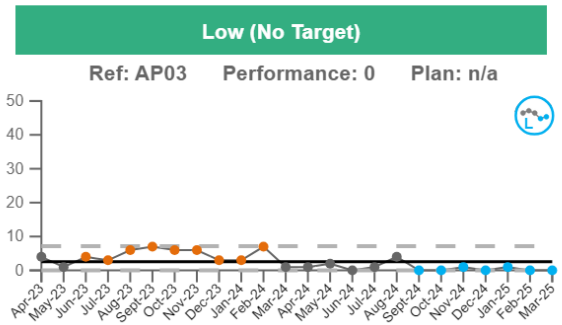
Assaults on Patients - No Physical Harm



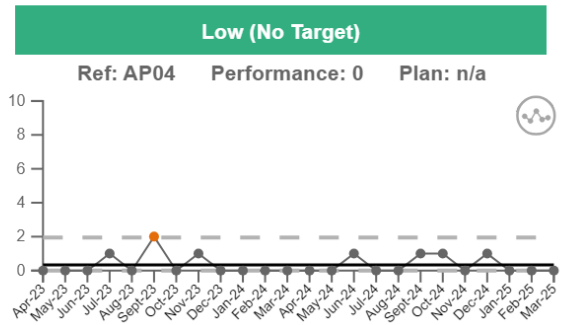
Assaults on Patients - Low Physical Harm



Assaults on Patients - Moderate Physical Harm



Assaults on Patients - Severe Physical Harm

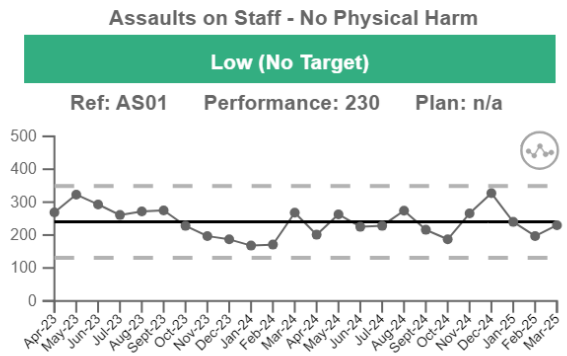


In the last 24 months there have been 0 fatal assaults on patients

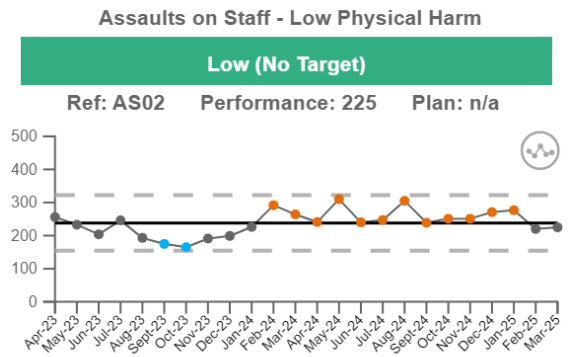
The system shows 0 assaults on patients over the last 24 months with no type of harm currently recorded

Assaults on Staff - Type of Harm

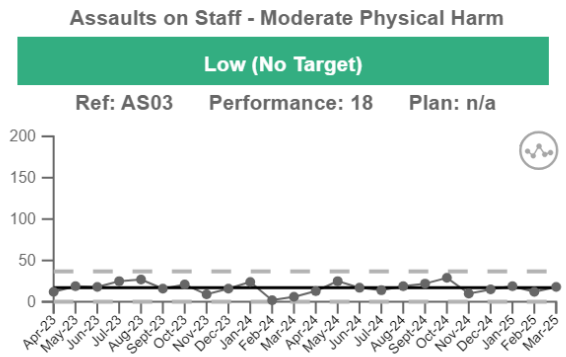
Assaults on Staff - No Physical Harm



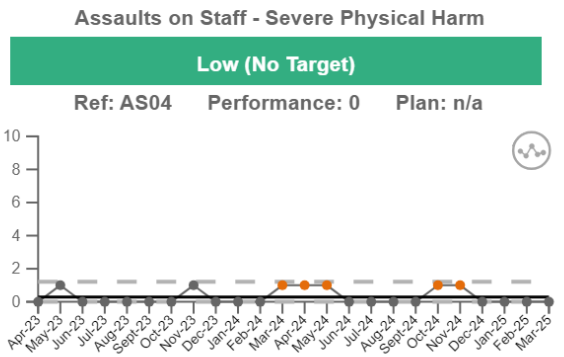
Assaults on Staff - Low Physical Harm



Assaults on Staff - Moderate Physical Harm



Assaults on Staff - Severe Physical Harm



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

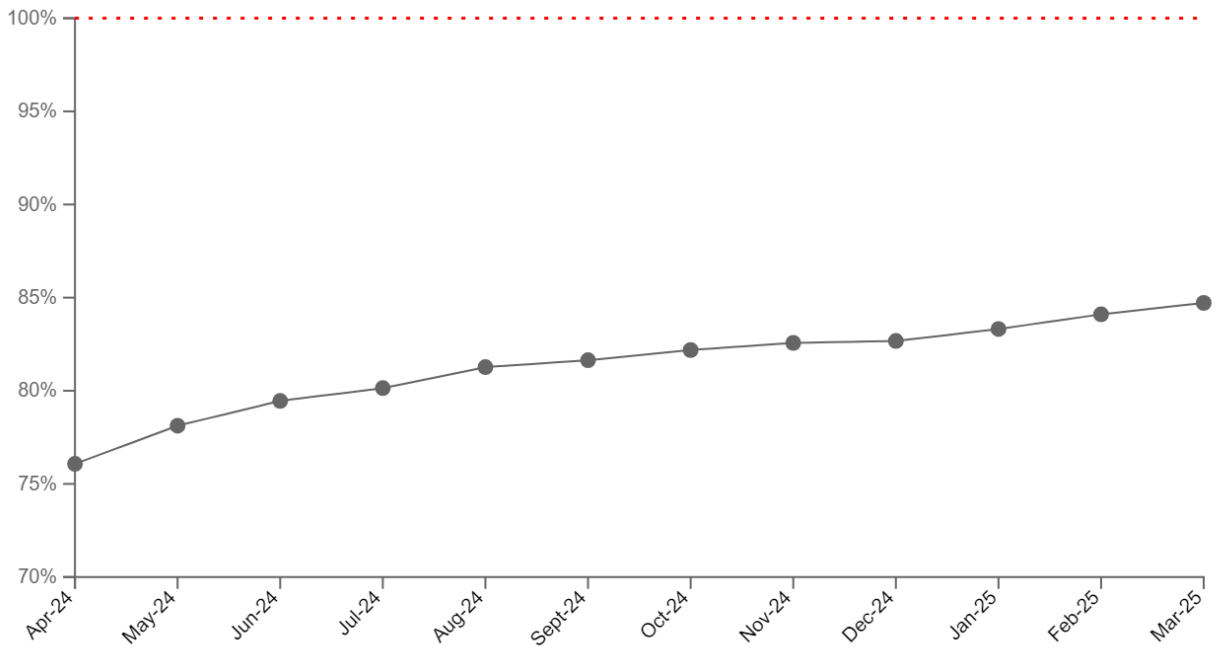
Q06 % of patients with a Safety Plan

% of patients with a Safety Plan

Risk Rating: Med (Monitoring)

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

84.7%	tgt. 100% n. 30,594 d. 36,114	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	83.3%	23,175	27,818	100%	SPC n/a	SPC n/a
Inpatient Care Group	96.7%	699	723	100%	SPC n/a	SPC n/a
Specialist Care Group	88.5%	6,531	7,383	100%	SPC n/a	SPC n/a
Support & Corporate	99.5%	189	190	100%	SPC n/a	SPC n/a

Feedback

What the chart tells us

In March 84.7% of patients were reported to have a Risk Management and Personalised Safety Plan.

Root Cause of the performance issue

- Early evaluation shows that staff are often unable to differentiate a risk management plan from a safety plan. Evaluation is also showing that staff sometimes see safety planning as a necessity only for patients at risk of self-harm or suicide and not for patients with other presentations.

Improvement Actions

- An evaluation framework has been devised internally (based on NICE/NCISH metrics).
- Evaluation highlights that staff do not always understand the difference between a risk management plan and a safety plan.
- In response to evaluation, enhanced staff training is being developed. This will be specific to the various services we host. The videos are being developed by staff, people with lived experience and CNTW Academy
- External evaluation of the quality of risk assessments and safety plans is also being undertaken by National Institute for Health and Care Excellence (NICHE), using similar metrics
- Care groups will discuss performance metrics and quality evaluation in governance meetings to develop training / action plans suitable for their patient groups. This is discussed within the Quality Standards meetings and escalated by exception to Transformation Steering Group (TSG) or Business Development Group Quality (BDG-Q)
- The biopsychosocial risk framework and safety planning policy is available to staff on the intranet
- A continuous quality improvement process is proposed, whereby the groups have nominated leads to audit the quality of risk assessments and safety plans.
- Continued focus on compliance position in governance meetings
- The Inpatient Care Group are taking forward additional training to further strengthen the quality of risk assessments.
- The clinical audit dept will support the groups' analysis of the quality of risk assessments and safety plans

Expected impact and by when

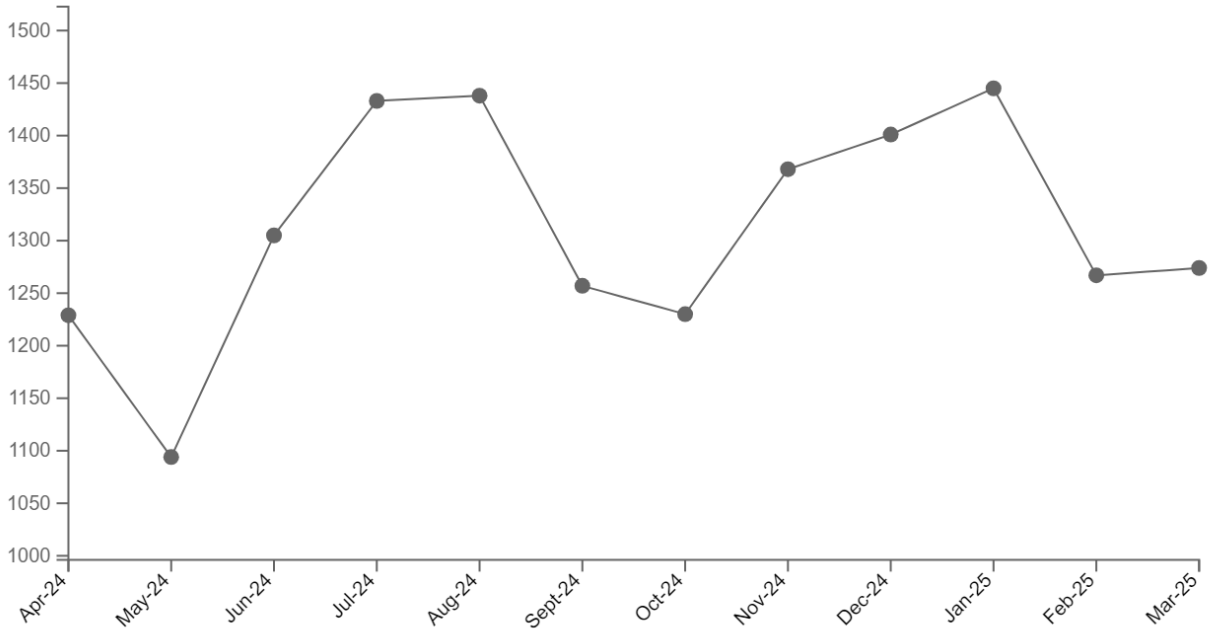
By end quarter 2, 2025, we expect to see from all the feedback mechanisms and clinical evaluation that there are demonstrable improvements in the quality of risk assessments and safety plans. Accountability for ongoing evaluation, assurance and action plans will devolve to care groups by April 2025. Themes regarding the quality of risk assessment and safety plans will be presented by groups to Patient Safety learning and Improvement Panel (PSLIP).

Q07 Reducing incidents of self-harm

Risk Rating: Med (Monitoring)

Number of incidents of self-harm

1,274	SPC n/a	SPC n/a	DQ - No Concern There are currently no concerns with the data quality of this indicator



Care Group	Performance	Target	Variation	Assurance
Community Care Group	709	n/a	SPC n/a	SPC n/a
Inpatient Care Group	320	n/a	SPC n/a	SPC n/a
Specialist Care Group	245	n/a	SPC n/a	SPC n/a
Support & Corporate	0	n/a	SPC n/a	SPC n/a

Feedback

What the chart tells us

In March there was an increase of incidents of self-harm from 1,267 in February to 1,274 in March.

Root Cause of the performance issue

- Figures in CYPS remain high across a range of services.
- Reported incidents of self-harm have increased in South Access CBU since the launch of 111.
- There are particularly high levels of self-harm in our female facilities within the acute pathway (87% of activity YTD in female wards; ratio of female to male wards 1:2). Alnmouth and Lowry report high levels of self-harm in month (2 patients accounting for 60% or more of the incidents in each ward). Lamesley, Alnmouth and Longview have reported the highest levels of self-harm YTD, with self-harm incidents being reflective of the complexity of the patients within the wards
- **Improvement Actions**
- The data reported has been realigned to ensure accurate reporting from April 2024
- Mitford; part of CQC action plan and reviewed post incident and audited. A full table is available for overview of all incidents where harm is caused, including self-harm. Actions taken and reviewed by team.
- The 3 care groups will review their self-harm incident data and outline governance processes and assurance to reduce self-harm incidents in their services using evidence-based interventions
- A new self-harm policy is under development and due out for consultation in July 2025.
- A self harm workshop will take place on 7th May with representation from care groups (operational and clinical staff) & corporate services to identify 3 SMART priorities, what needs to be done to achieve them, and how self harm and suicide prevention will be reflected in group assurance and governance meetings.
- Evaluation metrics (based on NICE quality standards 34 & 189 , the NCISH toolkit and other evidence-based research) will be agreed at this workshop. This will inform the IPR for 2025/2026 with respect to reducing self harm incidents and suicide prevention. Groups will provide assurance for IPR reporting.
- Enhanced staff training videos for safety planning (evidence-based intervention for self-harm & suicide prevention)
- Management of self-harm is individualised, and care planned for each person based on formulation and reviewed as required. Due to the individualisation, management can vary however in some cases observation increase, 1:1 sessions, reflection sessions, facilitating activity / OT activities, graded approach to intervention.
- Following these incidents debriefs occur which can be used to share learning across the inpatient care group.
- Adopt and monitor the quality of biopsychosocial risk assessments with safety planning on inpatient wards.
- Work has commenced on the development of an inpatient female bed model with a focus on trauma informed care.
- Care Group has representation at the newly established Trustwide Self-harm and Suicide meeting.
- Oxehealth is alerting staff of self-harm incidents which potentially has a positive impact on severity.

Expected impact and by when

We would expect to see a reduction in incidents, based on the 3 SMART self harm and suicide prevention priorities (yet to be agreed).

Q08 Rights at Point of Detention

Record of Rights (Detained) Assessed Within 7 Days of Detention Starting

Risk Rating: Med (Monitoring)

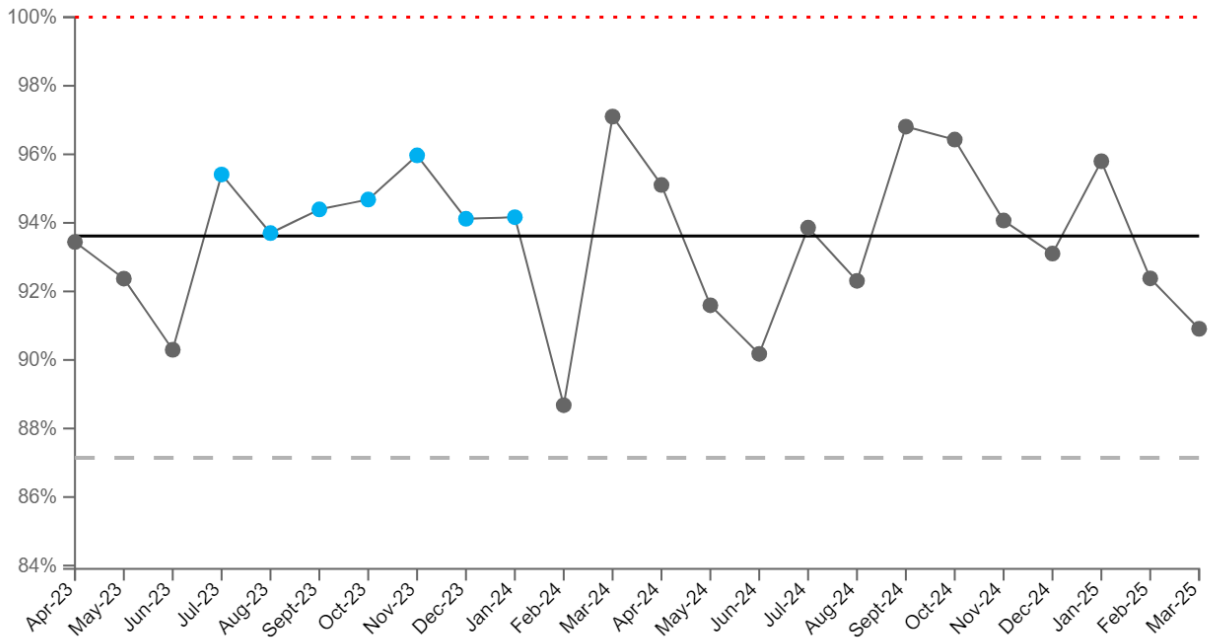
tgt. = target n. = numerator d. = denominator

90.9%		
	tgt.	100%
	n.	110
	d.	121

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



Care Group	Performance	N	D	Target	Variation	Assurance
Inpatient Care Group	89.8%	97	108	100%	Normal Variation	Achieve at Random
Specialist Care Group	100.0%	13	13	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Compliance in this area continues to fluctuate and is reported for March at 90.9%. Without change, performance will remain consistently off target.

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 completed at the point of admission.
- Availability and consistency of training.
- Gap in education from university evident by Preceptors having a lack of understanding of rights and their roles and responsibilities in relation to this.

Improvement Actions

- Specialist group detentions have improved following CBU actions and addressed in quality standards.
- Nursing staff to continue carry out MHA weekly/monthly checks on aspects of Mental health Legislation (MHL) including the monitoring of ensuring patients have been given their rights within 7 days of being detained under the MHA. Staff revisit rights within the time specified on the H3L form on Rio.
- MHL specialist participates in CQC mock visits and reviews compliance, feeding 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. and that staff revisit rights within the time specified on the H3L form on Rio.
- 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 must ensure patients can exercise their right to appeal when detained under the MHA.
- Patients' rights awareness e-learning package developed and on intranet.
- The Mental Health Legislation Steering Group (MHLSG) meet quarterly to discuss the giving of patients' rights, this will be raised within the Care Groups monthly and actions reported
- Increase compliance in Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty (DOLS) training (impacted by cancelled courses).
- Continued awareness raising in relation to supporting material including rights on a page poster (outlines key duties in relation to the reading of rights).
- As the E-MDT embeds the responsibility of discussing rights at the point of detention can be devolved/ shared across a range of disciples.
- Findings from a recent review being presented at the MHA Steering Group with proposed recommendations - the Group will take forward any supported recommendations.

Expected impact and by when

Performance continues to fluctuate improvement expected throughout 2025/26.

Q09 Record of Capacity/ CTT at point of detention

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 start date

Risk Rating: High (Action)

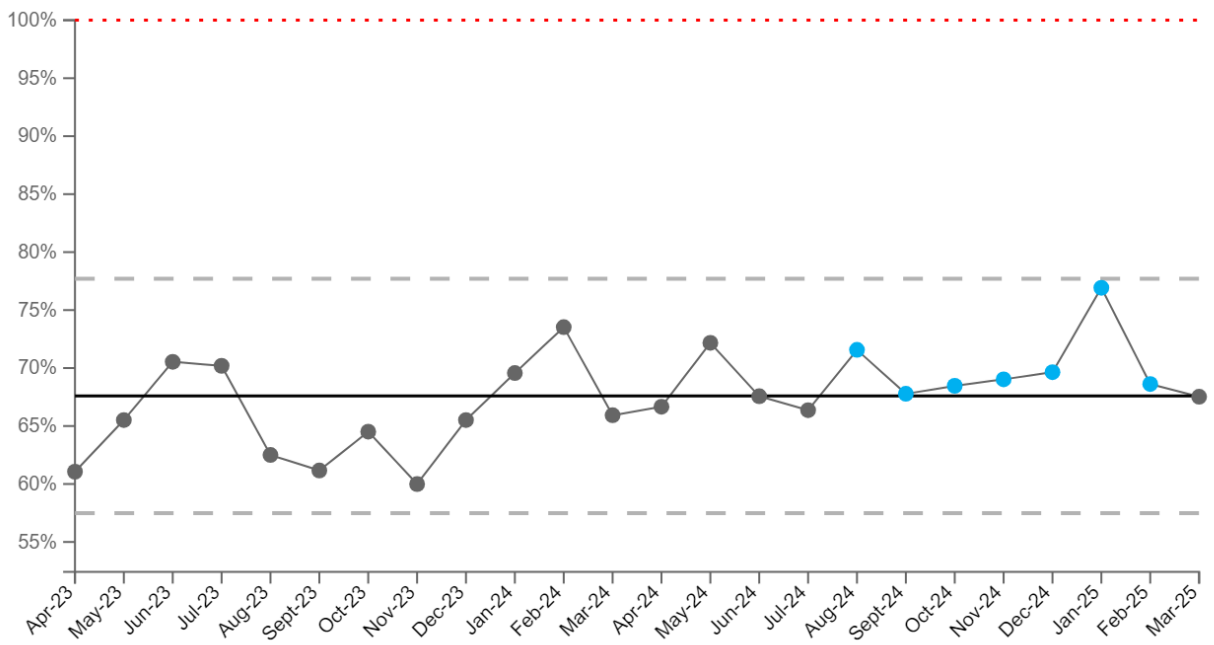
tgt. = target n. = numerator d. = denominator

67.5%	tgt.	100%
	n.	79
	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	69.5%	73	105	100%	Normal Variation	Consistently Off Target
Specialist Care Group	50.0%	6	12	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

March compliance is reported at 67.5% 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 – this is featured in quality meetings for specialist care group
- Local form rather than legal requirement (legal requirement at 3 months).
- Significant number of pertinent requirements to be complete at the point of admission

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
- MHA office continue to prompt Responsible Clinicians (RC) to complete this form at point of detention.
- Discussed in several medical / consultant meetings to raise awareness and focus.
- An audit on consent to treatment has been completed (awaiting outcome), the outcome and recommendations will highlight to the groups' actions required for improvement.
- Continued focus on compliance position in governance meetings.
- Specialist care group have highlighted this as an area of focus, secure services have established plans to improve the metric.
- Ward level performance position shared with Consultants / Responsible Clinicians.
- Discussions to be had at an appropriate meeting focusing on the expectations and repercussions for all staff supporting the delivery of the treatment plan.

Expected impact and by when

- Performance continues to fluctuate but improvement has been made and expected to continue but, the target will not be met without significant change.

A01 Active Inappropriate Out of Area Placements (OAPs)

Active inappropriate adult acute MH Out of Area Placements (OAPs)

Risk Rating: Med (Monitoring)

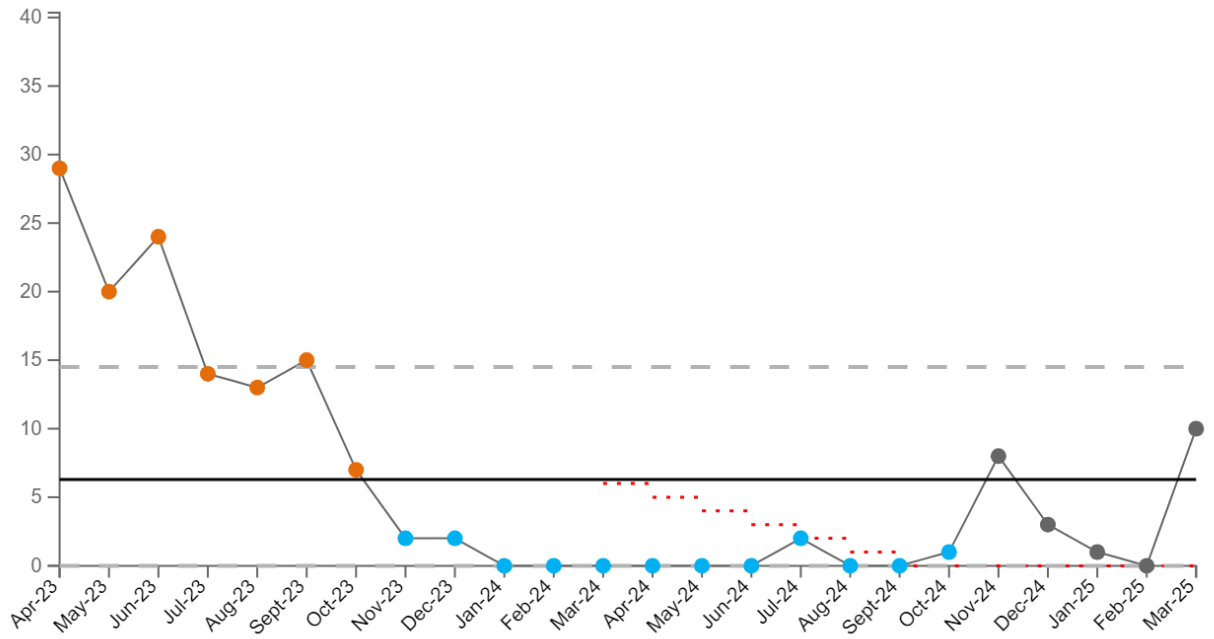
tgt. = target n. = numerator d. = denominator

10	tgt.	0
	n.	10
	d.	10

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



Care Group	Performance	N	D	Target	Variation	Assurance
Inpatient Care Group	10	10	10	0	Normal Variation	Achieve at Random

Feedback

What the chart tells us

There were 10 active out of area placements reported as because of 31st March 2025 within the adult acute pathway. In total there were 17 out of area placements during March, of which seven were discharged in the month.

Root Cause of the performance issue

- Bed pressures remain and an increase in out of pathway patients has been noted.
- A detailed review on the increase in out of area cases is taking place and has identified a number of key actions which are being implemented to recover the position. They include a refocus on effectiveness of home based treatment, management of unwell patients in the community and wrap around plans, increased length of stay in key ward areas and PLT/crisis interface as part of the urgent care pathway.

Improvement Actions

- Enhanced bed management close working with localities.
- Revised focus of the daily flow meetings to support proactive planning (discharge & demand).
- Multi-agency Response Group (MaRG) incorporating local authorities, ICB and CNTW teams continue to be in place.
- Daily surge planning meetings remain in place within representation from all Care Groups. An action plan has been developed to oversee key interventions.
- Extraordinary surge meeting has taken place in March and April given the significant bed pressures, coupled with a high number of out of area placements. Several considerations have been asked from inpatient consultants, and community services to be progressed including, crisis team thresholds, review of CRFD summary sheets and discharge opportunities.
- Pathways with significant long lengths of stay to be targeted.

Expected impact and by when

The actions above will support the reduction of OAPS and CRFD by June 2025.

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

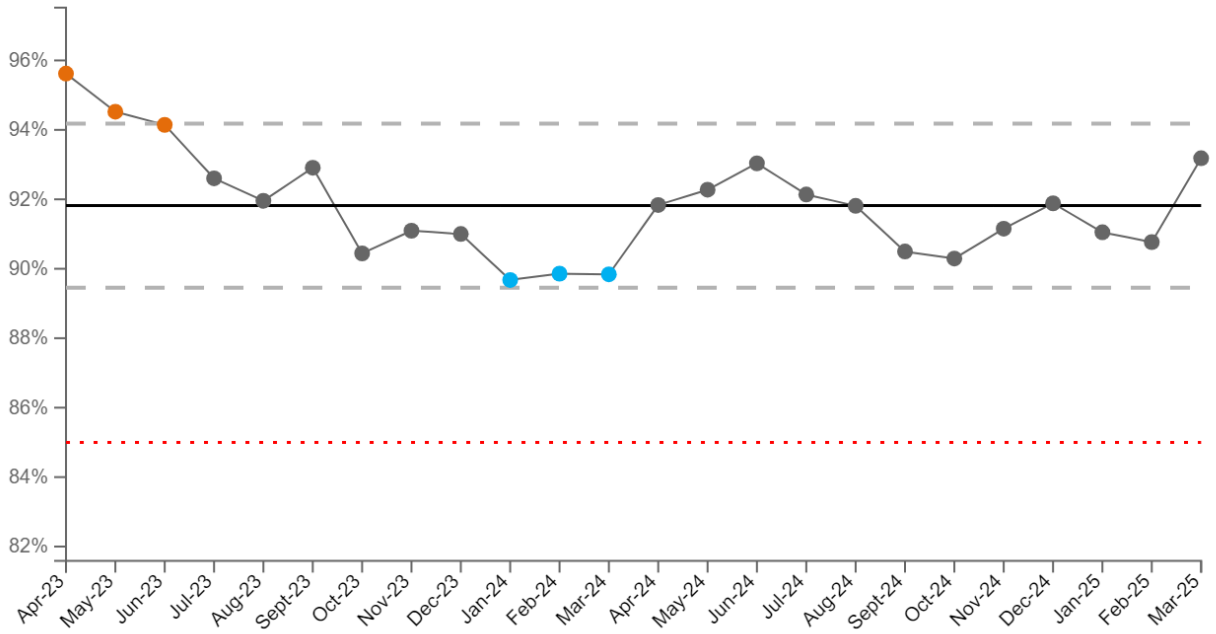
93.2%

tgt. 85%
n. 21,838
d. 23,436

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	101.5%	15,009	14,787	85%	Normal Variation	Consistently Off Target
Specialist Care Group	79.0%	6,829	8,649	85%	Improvement	Consistently Achieve

Feedback

What the chart tells us

Bed occupancy was reported at 93.2% in March, remaining higher than the optimal level of 85%. Without change, the standard will not be met.

Root Cause of the performance issue

- Bed availability in line with national performance and pressures.
- Unable to discharge patients who are clinically ready for discharge due to other pressures outside CNTW.

Improvement Actions

- Enhanced Bed Management discharge facilitators support wards and are attached to each locality for consistency.
- Weekly surge planning meetings remain in place within representation from all Care Groups. An action plan has been developed to oversee key interventions – examples of actions include consider a more effective access route to specialist beds (provider collaborative) for patients in mainstream acute services and discissions in relation to discharge roles and crisis.
- Admission & Discharge Continuous Improvement Group Meeting in place.
- System wide working with third sector e.g., Multi-agency Response Group (MaRG) meetings.
- Work is ongoing in relation to implementing an appropriate 7 day working model. This will require considerable work to ensure that key staff groups are available to undertake a senior decision-making role (IPQT funded initiative).
- Draft service model developed for a Trust-wide service to scaffold patients admitted to adult wards with a learning disability and or autism with behaviour that challenges (IPQT funded initiative).

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)

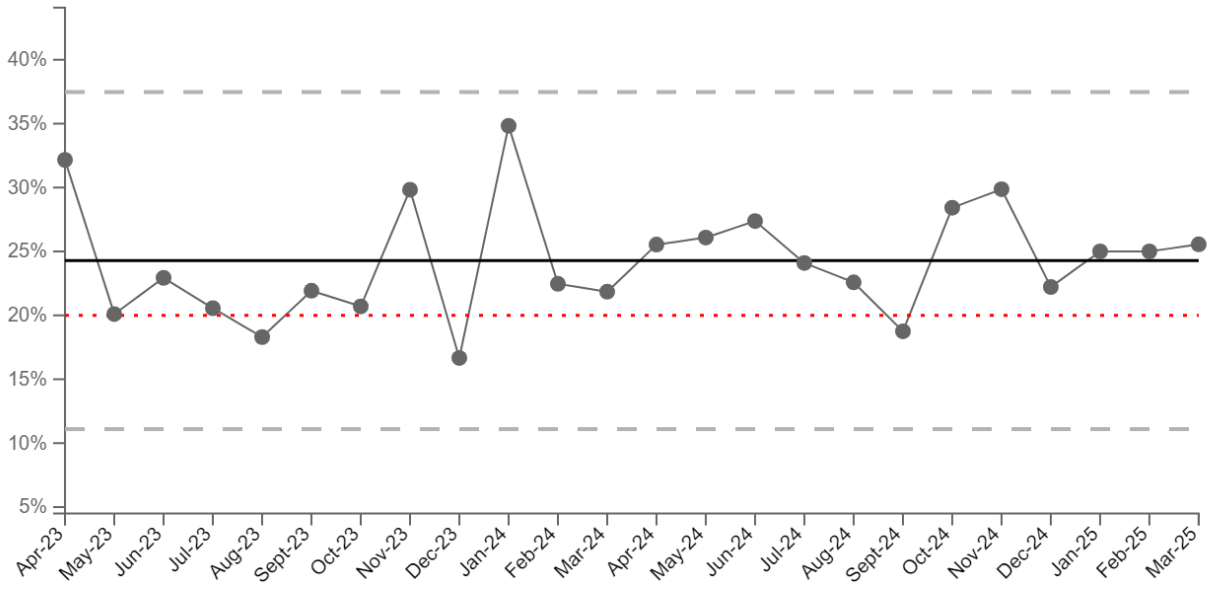
tgt. = target n. = numerator d. = denominator

25.6%		
	tgt.	20%
	n.	23
	d.	90

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



Business Unit	Performance	N	D	Target	Variation	Assurance
Central Inpatient CBU	37.5%	6	16	20%	Normal Variation	Achieve at Random
Neuro Rehabilitation & Specialist Services CBU	100.0%	2	2	20%	SPC n/a	SPC n/a
North Cumbria Inpatient CBU	10.3%	3	29	20%	Normal Variation	Achieve at Random
North Inpatient CBU	31.8%	7	22	20%	Normal Variation	Achieve at Random
South Inpatient CBU	23.8%	5	21	20%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In March 25.6% of patients were discharged where the length of stay exceeded 60 days. Data relates to adult acute wards within the inpatient care group and Gibside ward within the specialist care group.

Root Cause of the performance issue

- High levels of risk and need evidenced by high detention rates within the acute wards.
- Prolonged period to achieve treatment optimisation due to complexity.
- Medication changes and stabilisation (treatment resistant cohort).
- 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. 6 of the 23 discharges with an over 60 days LOS were CRFD (26.1%).

Improvement Actions

- Admission & Discharge Continuous Improvement Group Meeting in place.
- Focus on patient discharge from admission.
- Daily huddles are underway.
- Introduction of EMDT commencing on acute wards (from Q1 25/26). This will enhance the input across a range of disciples, to improve the therapeutic offer.
- Utilising the non-recurrent CRFD funding to support with overcoming barriers to discharge where possible e.g., funding for individualised enablers.
- Meetings are in place with the local authorities to review Clinically Ready for Discharges.
- Draft service model developed for a Trust-wide service to scaffold patients admitted to adult wards with a learning disability and or autism with behaviour that challenges (IPQT funded initiative).

Expected impact and by when

It is expected that LOS will remain within the expected range but the actions above are supporting and maintaining performance.

A04 % OP inpatients discharged with LOS > 90 days

Number of older adult inpatients discharged during the reporting period with length of stay > 90 days (Q&P Metric 2428)

Risk Rating: Med (Monitoring)

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

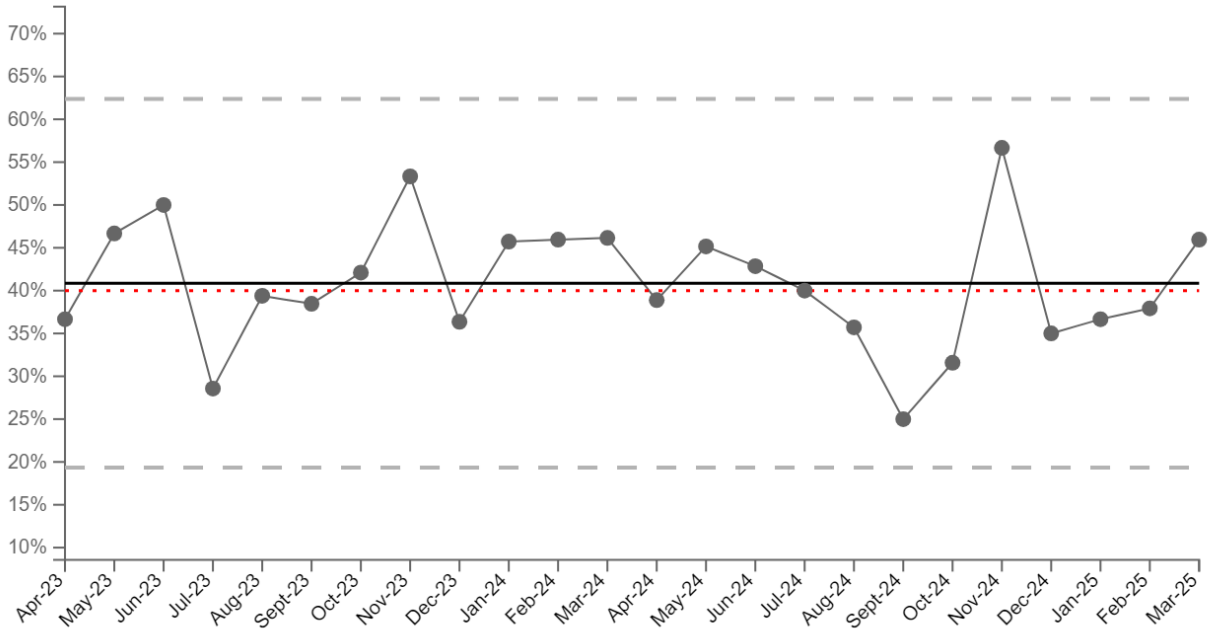
46.0%

tgt.	40%
n.	17
d.	37

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



Business Unit	Performance	N	D	Target	Variation	Assurance
Central Inpatient CBU	40.0%	4	10	40%	Normal Variation	Achieve at Random
North Cumbria Inpatient CBU	88.9%	8	9	40%	Normal Variation	Achieve at Random
North Inpatient CBU	11.1%	1	9	40%	Normal Variation	Achieve at Random
South Inpatient CBU	44.4%	4	9	40%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In March 46.0% of patients were discharged where the length of stay exceeded 90 days.

Root Cause of the performance issue

- Delayed discharges due to challenging and complex presentations and limited appropriate housing and or social support. 11 of the 17 discharges with an over 90 days LOS were CRFD (64.7%).
- Complex mental health and physical health needs requiring prolonged assessment and formulation and multiple or prolonged admission to Acute Trusts.
- Lack of equable access to residential nursing homes (especially those where staff are equipped to use PMVA).

Improvement Actions

- Focus on patient discharge from admission.
- Daily huddles are underway.
- Introduction of Enhanced-MDT commencing on acute wards (from Quarter 1 25/26) This will enhance the input across a range of disciples, to improve the therapeutic offer.
- Utilising the non-recurrent CRFD funding to support with overcoming barriers to discharge where possible.
- Meetings are in place with the local authorities to review Clinically Ready for Discharges.
- Continued work with Cumberland Council in relation to the development of robust intermediate care options/ models that would support the timely discharge of CRFD patients.

Expected impact and by when

It is expected that LOS will remain within the expected range but the actions above are supporting and maintaining performance.

A05 Clinically Ready for Discharge (formerly DTOC)

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

Risk Rating - **High (Action)**

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

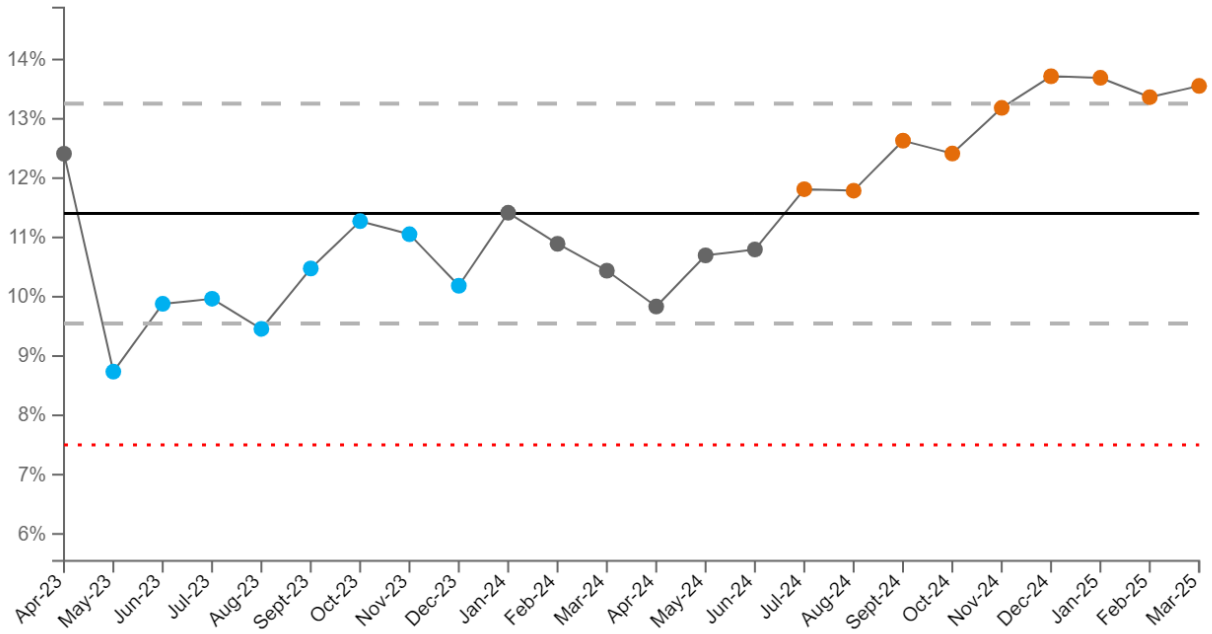
13.6%

tgt. 7.5%
n. 2,499
d. 18,437

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

Concern
There is concern because this indicator is increasing

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	14.9%	2,220	14,926	7.5%	Concern	Consistently Off Target
Specialist Care Group	8.0%	279	3,511	7.5%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In March 13.6% of patients were Clinically Ready for Discharge (CRFD). Within CYPS 9.5% of current patients (2) at 31.03.25 were recorded as CRFD (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 enabling appropriate support and care packages.
- The % CRFD bed days continues to remain high and a significant pressure. There have been reductions in CRFD bed days in the acute and older people's pathways in month, with further increases in the rehab and learning disability pathways. The highest % of CRFD bed days is in Central's rehabilitation pathway (30% of CRFD bed days).

Improvement Actions

- Strengthened discharge team and process being implemented.
- Targeted approach to pathways (rehabilitation), wards and local authority areas with greatest challenges with CRFD being implemented.
- Utilising the non-recurrent CRFD funding to support with overcoming barriers to discharge where possible (e.g., funding for individualised enablers, repatriation costs, CRFD practitioners (Dec 24 to Mar 25) and 7-day working for EBM). There has been agreement for EBM to hold an allocation to support discharge in 25/26.
- Engagement with the ICB in terms of our involvement in the ICB led 'Better homes and healthier lives Programme'.
- Senior Case Managers have established a weekly meeting with the ICB Senior Head of Complex Case Management, and the Heads of Complex Care and Case Management. This meeting provides a forum for each organisation to escalate issues, seek advice and signposting, and alert each other to any individuals who may require extensive packages of care or at risk due to placement breakdown.

Expected impact and by when

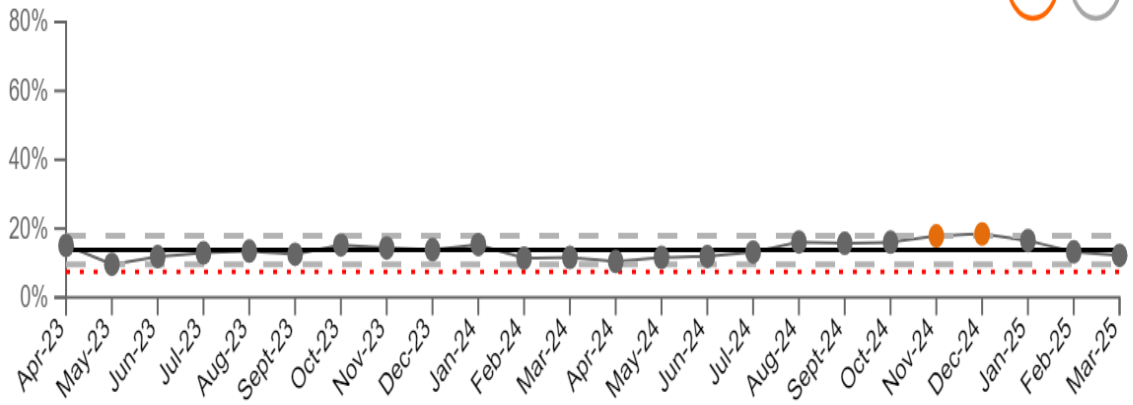
The impact of the above actions are being monitored daily with anticipated improvement to be seen from June 2025.

A05 Clinically Ready for Discharge (formerly DTOC)

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

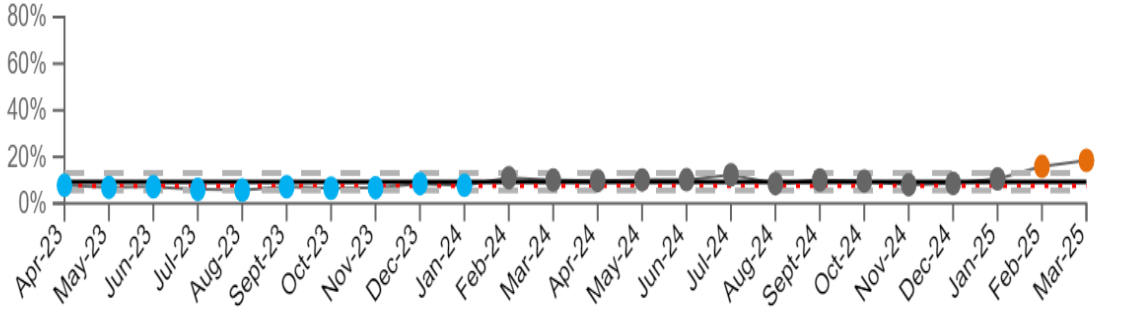
Adult Acute and PICU

Ref: A05 Performance: 11.3% N. 805 D. 7,102 NHSE Std: 7.5%



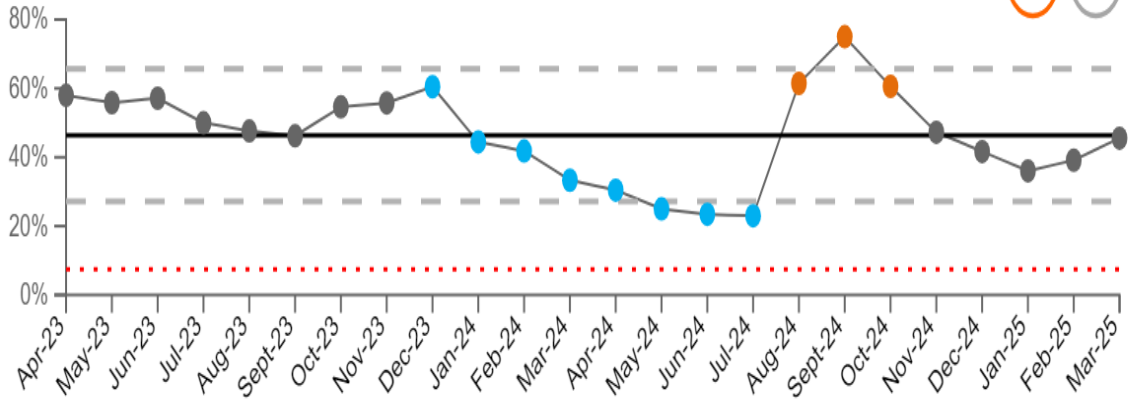
Adult Rehabilitation

Ref: A05 Performance: 18.5% N. 794 D. 4,296 NHSE Std: 7.5%



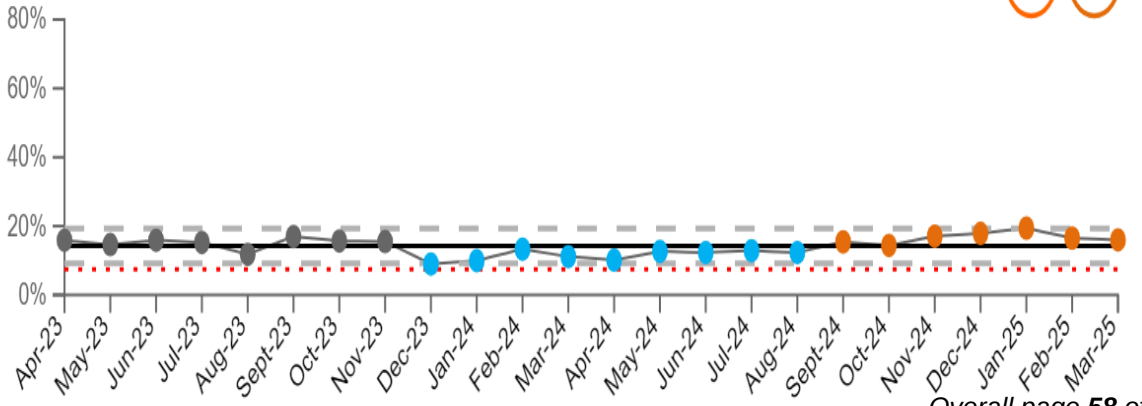
Learning Disability

Ref: A05 Performance: 45.6% N. 87 D. 191 NHSE Std: 7.5%



Older Persons

Ref: A05 Performance: 16.0% N. 534 D. 3,337 NHSE Std: 7.5%



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

% 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

Risk Rating: **High (Action)**

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

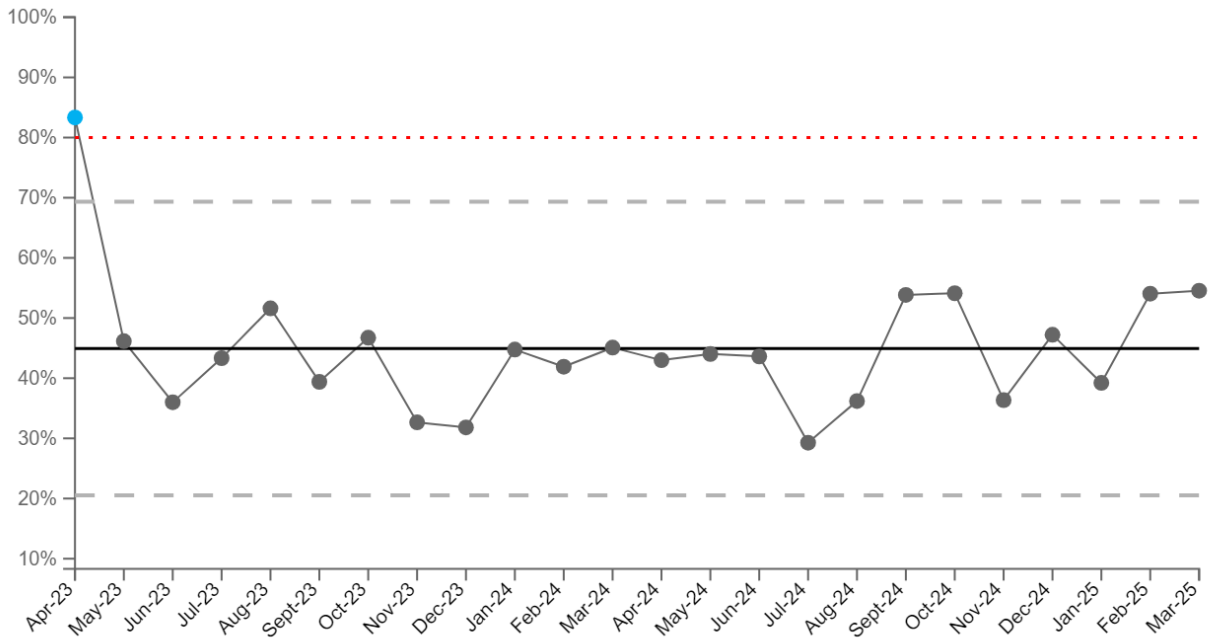
54.6%

tgt.	80%
n.	18
d.	33

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 - Investigating
There have been data quality concerns raised with indicator



Place Team	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	44.4%	8	18	80%	Normal Variation	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	62.5%	5	8	80%	Normal Variation	Consistently Off Target
Sunderland & South Tyneside Place Team	71.4%	5	7	80%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Very urgent referrals seen within 4 hours achieved 54.6% , this is an increase from 54.1% in February 2025 but there was a decrease overall of referrals which were classed as very urgent in March.

Root Cause of the performance issue

- Data quality/recording issues:
  - Duplicate referrals opened to teams – same team and different teams due to 'mutual aid' ways of working. Appointments outcome not being complete. Appointments not being put in Rio diaries. Referrals opened incorrectly (72hrs & 136 suite). Incorrect referral urgency allocated
- Staffing shortages particularly with Band 6s.
- Triage system being reviewed to reduce missed opportunities for contact with patients.
- Demand is outstripping capacity, particularly around the 136-staffing model and the impact this has on the service.

Improvement Actions

- Currently crisis staffing is challenging across all localities, active recruitment is underway, a rolling advert is place on the national NHS jobs portal within North Cumbria.
- 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 and monthly oversight of performance.
- Standardisation of referral recording urgency across teams implemented by Access Oversight sub-group
- Staff continue to be supported to correct data quality/recording issues
- Updated process agreed to ensure clock is started once crisis hub triage clinician agrees crisis assessment is required. This is in line with national guidance and other Trusts recording processes.

Expected impact and by when

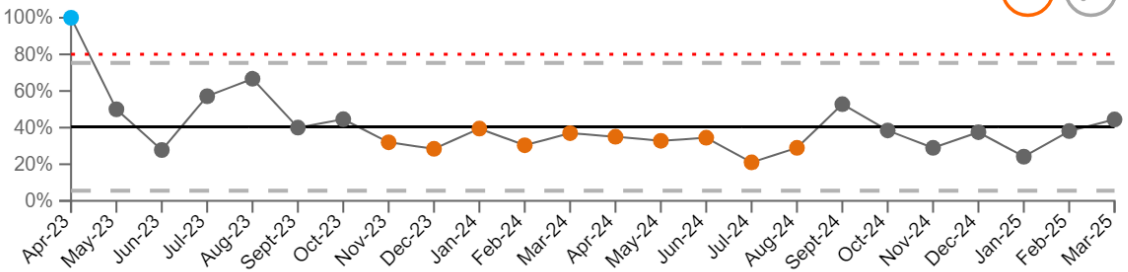
Staffing remains an ongoing challenge within North Cumbria. As the recruitment process progresses and additional staff members are confirmed, the trajectory for performance improvement will be closely monitored. It is anticipated that addressing staffing gaps will lead to a noticeable improvement in overall performance. This approach aims to ensure that staffing levels are aligned with operational needs.

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

% 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

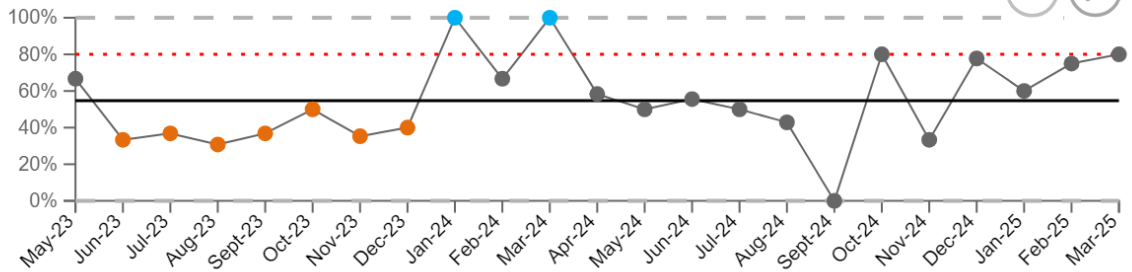
Newcastle & Gateshead Access CBU

Ref: A06 Performance: 44.4% N. 8 D. 18 CNTW Traj: 80%



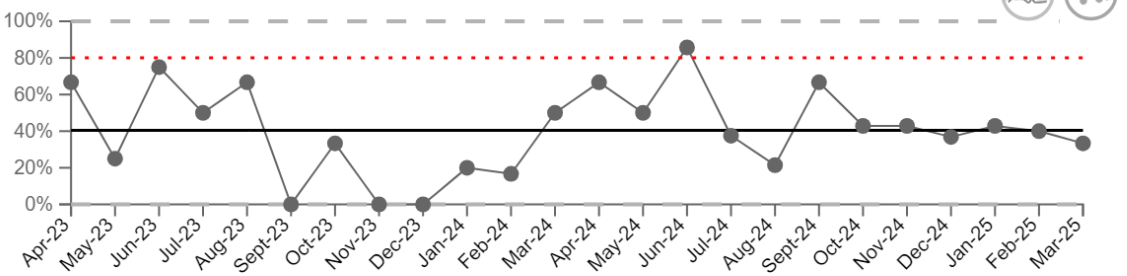
North Cumbria Community & Access CBU

Ref: A06 Performance: 80.0% N. 4 D. 5 CNTW Traj: 80%



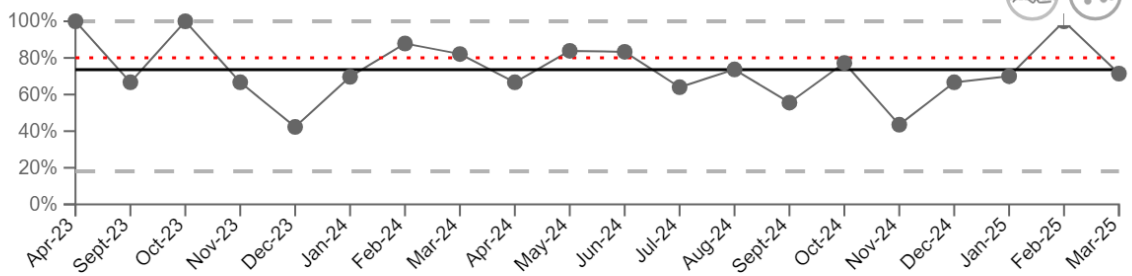
Northumberland & North Tyneside Access CBU

Ref: A06 Performance: 33.3% N. 1 D. 3 CNTW Traj: 80%



Sunderland & South Tyneside Access CBU

Ref: A06 Performance: 71.4% N. 5 D. 7 CNTW Traj: 80%



Feedback

Performance:

The performance percentage fluctuates significantly at CBU level due to the low numbers or patients requiring a very urgent response. Newcastle and Gateshead, and Northumberland and North Tyneside have the most significant challenges with their average performance levels around 40%. North Cumbria has an average performance of 56% with Sunderland and South Tyneside reporting around 70%. All areas saw an improvement in performance except for Northumberland and North Tyneside which showed a deterioration in February.

Recovery overview:

There are challenges in capacity in the Triage process due 30% increase in demand following the go live of NHS 111. There are recruitment processes in place to increase the capacity to meet the demand which will improve the performance. The performance and data quality issues are monitored on a regular basis. There are no national targets but, the Trust have set a trajectory to be at 80% for the 4-hour response rate by March 2025.

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)

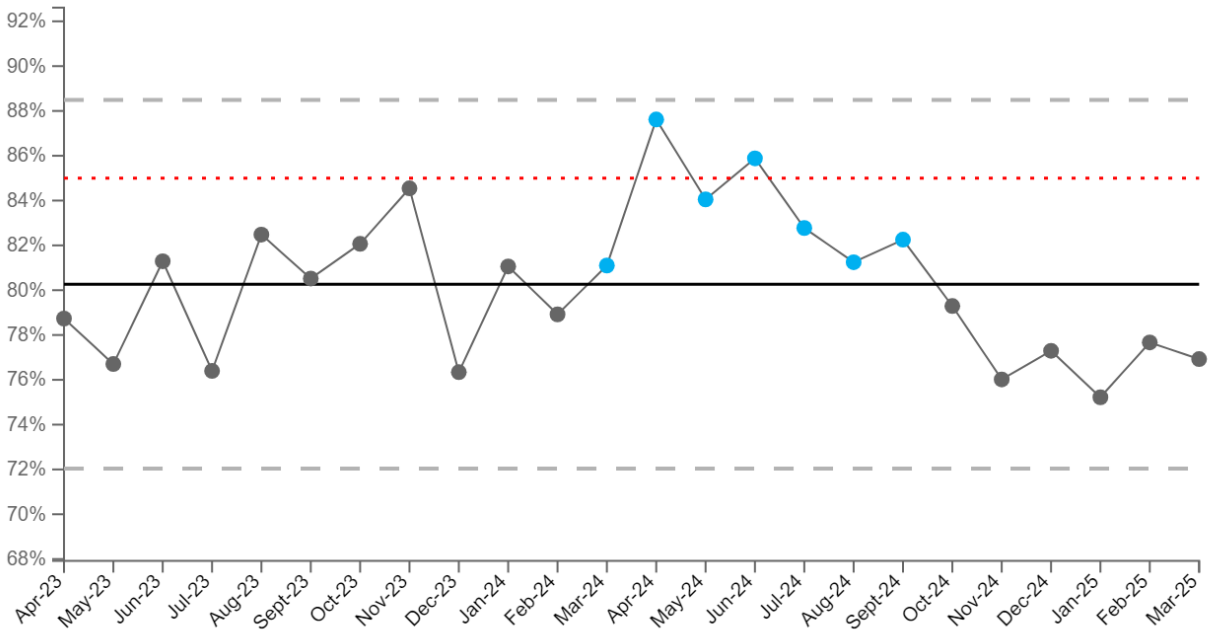
tgt. = target n. = numerator d. = denominator

76.9%	tgt.	85%
	n.	340
	d.	442

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 - Investigating
There have been data quality concerns raised with indicator



Place Team	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	75.9%	82	108	85%	Concern	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	73.8%	149	202	85%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	82.6%	109	132	85%	Concern	Achieve at Random

Feedback

What the chart tells us

Urgent referrals seen within 24 hours achieved 76.9% in March.

Root Cause of the performance issue

- Staffing shortages particularly with Band 6s.
- High level of clinical activity.
- Some data quality/recording issues
- Demand is outstripping capacity, particularly around the 136-staffing model and the impact this has on the service.
- CYPS Crisis providing input to ED in areas where there is no CYPS PLT commissioned.

Improvement Actions

- Currently crisis staffing is challenging across all localities, active recruitment is underway, a rolling advert is place on the national NHS jobs portal within North Cumbria.
- 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 and monthly oversight of performance.
- We have standardised referral recording urgency across teams implemented by Access Oversight sub-group
- Staff continue to be supported to correct data quality/recording issues

Expected impact and by when

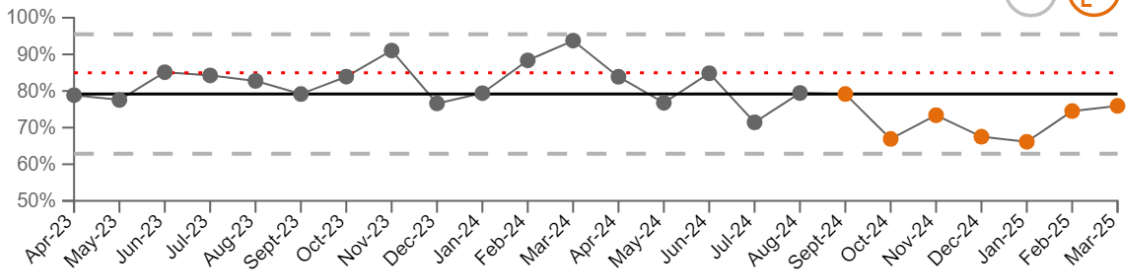
A recent decline has been observed, primarily due to short-term sickness, vacancies and clinical activity demand.

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

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

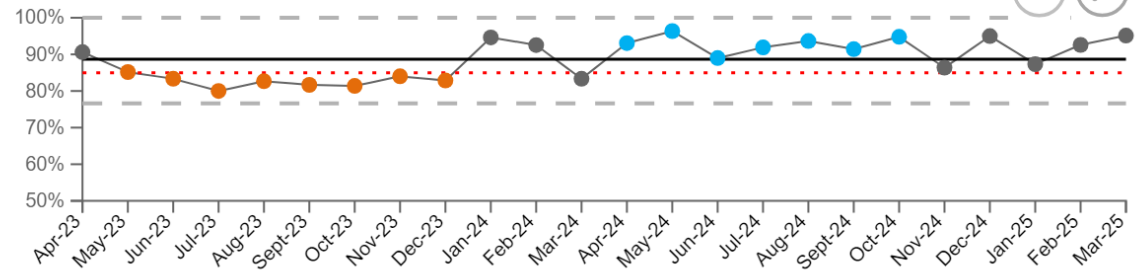
Newcastle & Gateshead Access CBU

Ref: A07 Performance: 75.9% N. 82 D. 108 CNTW Std: 85%



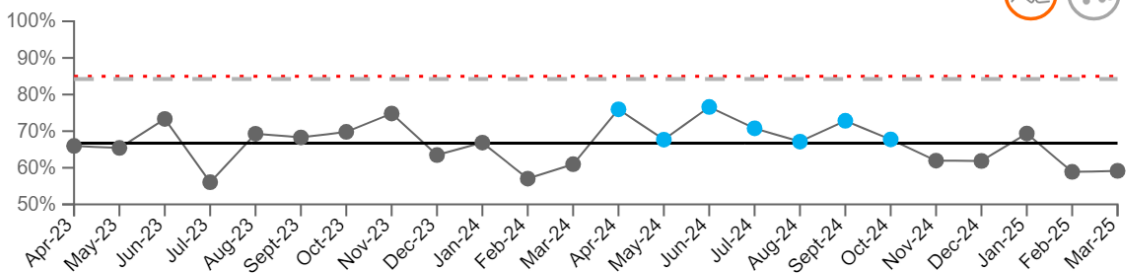
North Cumbria Community & Access CBU

Ref: A07 Performance: 95.1% N. 78 D. 82 CNTW Std: 85%



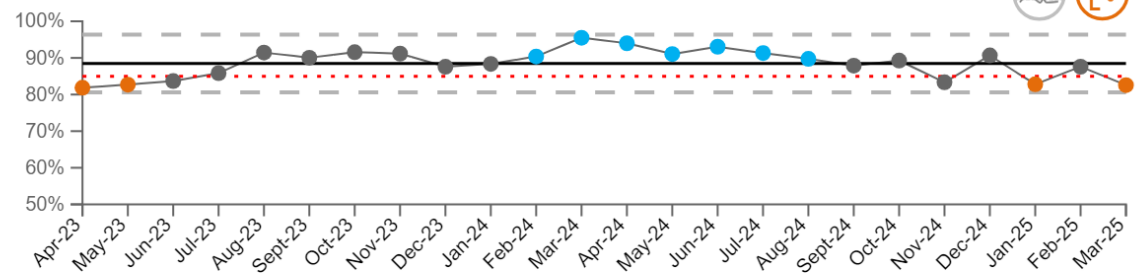
Northumberland & North Tyneside Access CBU

Ref: A07 Performance: 59.2% N. 71 D. 120 CNTW Std: 85%



Sunderland & South Tyneside Access CBU

Ref: A07 Performance: 82.6% N. 109 D. 132 CNTW Std: 85%



Feedback

Performance:

- Newcastle and Gateshead, have deteriorated in the last 8 months and have been below the target with an average of 79% against an 85% internal target
- Northumberland and North Tyneside have the most significant challenges with their average performance levels around 67% and have not improved and not met the target in 24 months.
- North Cumbria has met the 85% trajectory for every month this financial year since April and have an average performance of around 89%.
- Sunderland and South Tyneside are reported below target three times in the last five months but have remained above target prior to that for 16 months.

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

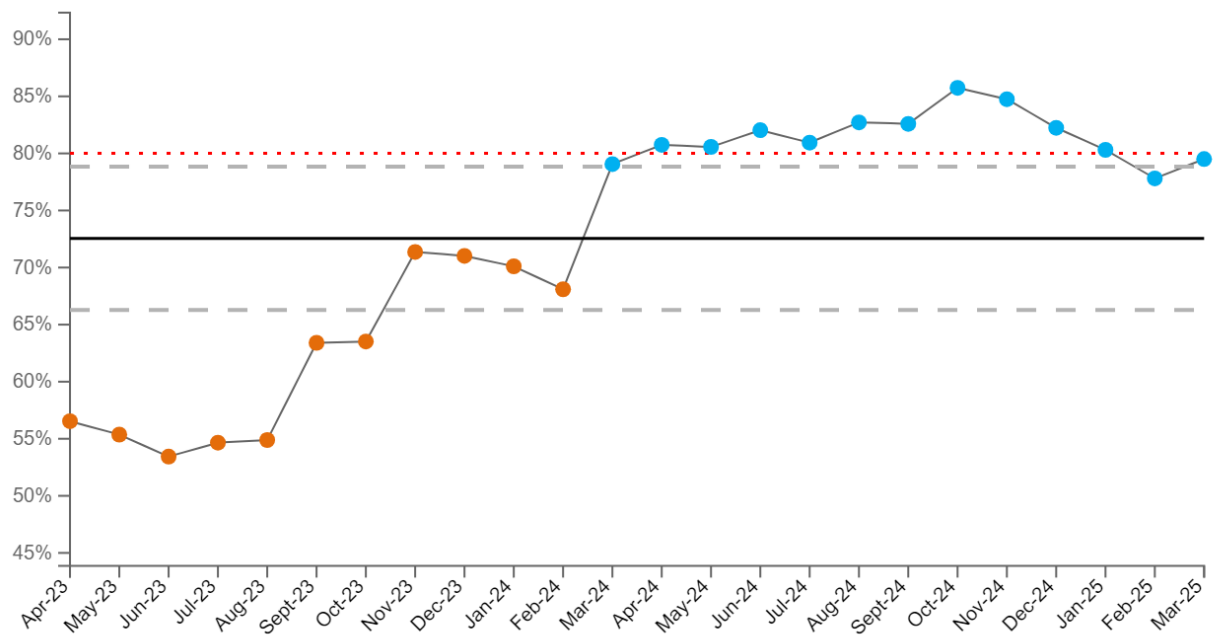
79.5%

tgt. 80%
n. 865
d. 1,088

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



Place Team	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	69.6%	289	415	80%	Improvement	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	76.9%	280	364	80%	Improvement	Consistently Off Target
Sunderland & South Tyneside Place Team	95.8%	296	309	80%	Improvement	Consistently Achieve

Feedback

What the chart tells us

PLT referrals seen within 1 hour, achieved 79.5% in March.

Root Cause of the performance issue

- Performance has been above target for a sustained period, however, has reduced slightly. This is same pattern as the previous year, between November-March, suggesting a seasonal impact.
- Issue with ED staff referring to PLT when patient is not medically fit, patients having physical needs seen to or they refuse to be seen which then causes breach of target.
- Staffing (recruitment/retention/sickness) remains a challenge.

Improvement Actions

- Ensuring there is a consistent and embedded approach to recording practices, incorrect appointment recording which impacts on performance.
- Review workforce and the planned return to work dates. Supporting recruitment and retention.
- Review of all breaches to identify any themes that can be fed into the Access Oversight Group guidance review

Expected impact and by when

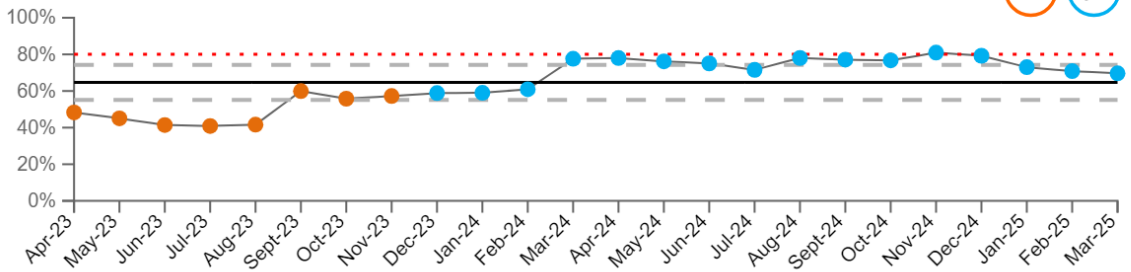
Improvement work remains ongoing, and improvements anticipated within Q1 2025/26 overall

A08 % PLT ED Referrals seen within 1 hour

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

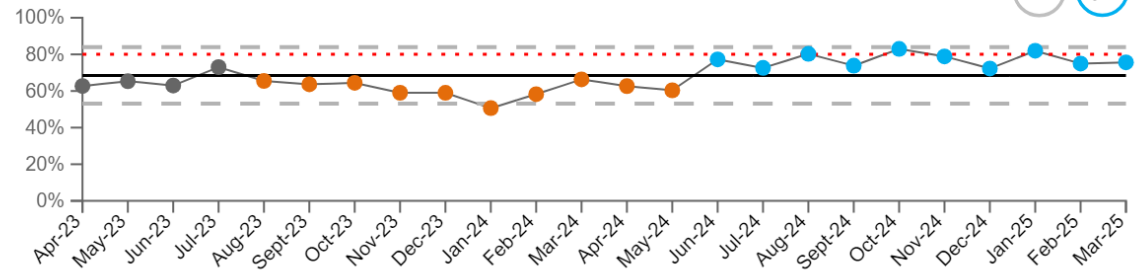
Newcastle & Gateshead Access CBU

Ref: A08 Performance: 69.6% N. 289 D. 415 CNTW Std: 80%



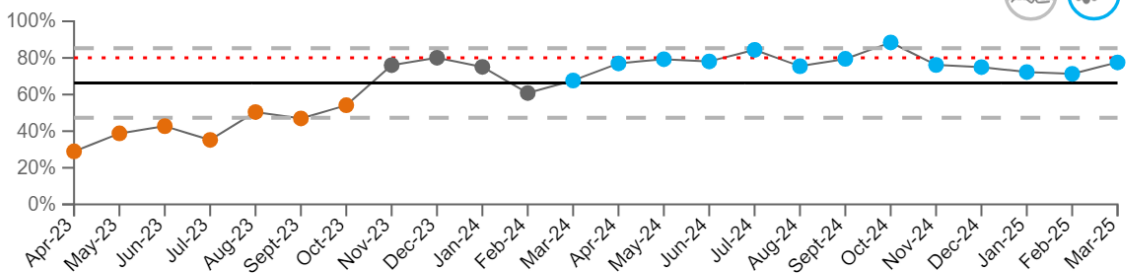
North Cumbria Community & Access CBU

Ref: A08 Performance: 75.6% N. 90 D. 119 CNTW Std: 80%



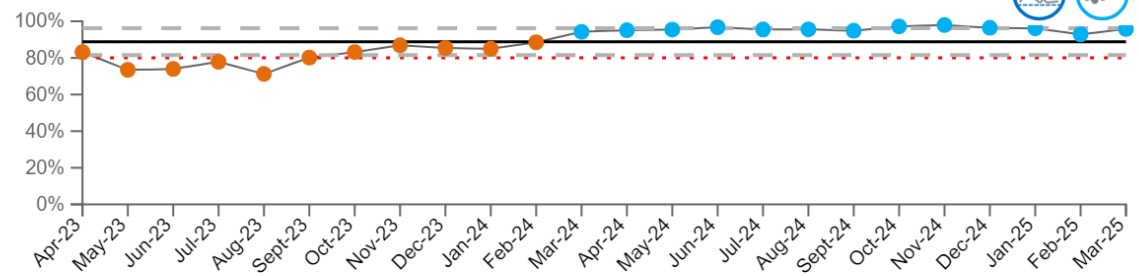
Northumberland & North Tyneside Access CBU

Ref: A08 Performance: 77.6% N. 190 D. 245 CNTW Std: 80%



Sunderland & South Tyneside Access CBU

Ref: A08 Performance: 95.8% N. 296 D. 309 CNTW Std: 80%



Feedback

- Sunderland and South Tyneside: Consistently meeting the target throughout 2024/25
- Newcastle and Gateshead, Northumberland, North Tyneside, and North Cumbria: Facing significant challenges, with average performance levels around 74%.

Operational Challenges:

Overnight Staffing: Issues arise when staffing levels between sites are insufficient, particularly when two practitioners are required for assessments due to safety concerns, or when patients are not medically fit for assessment. Additionally, variations in commissioned Liaison capacity between sites contribute to these challenges. Collaborative Improvement: These teams are working closely with acute department colleagues to improve response times and streamline the referral process, aiming to address performance gaps. Breach Review Process: Each team has implemented a structured process to review every instance where a breach exceeds one hour, ensuring accountability and continuous 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

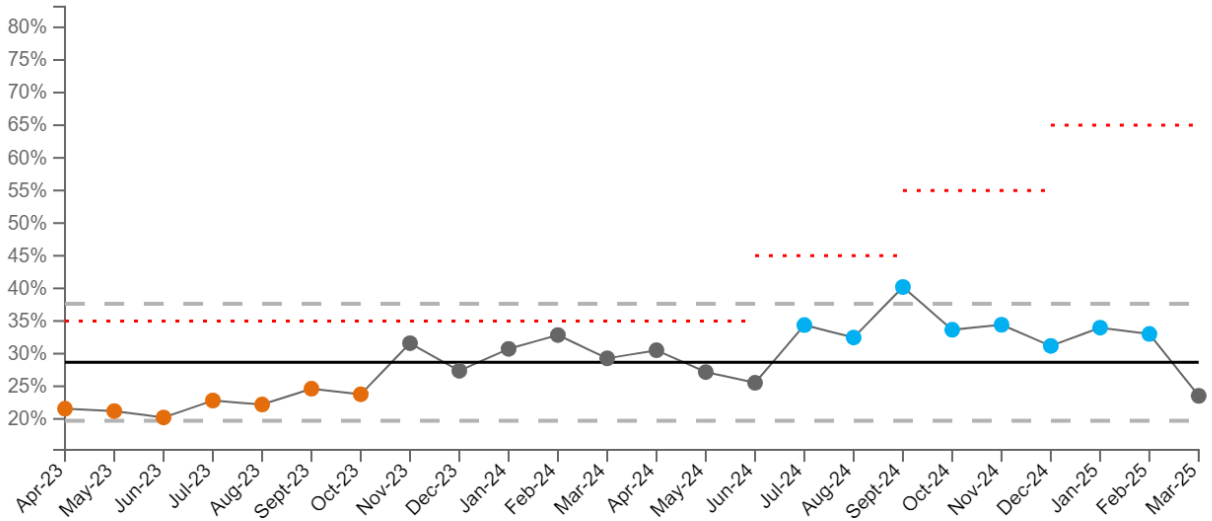
23.5%

tgt. 65%
n. 670
d. 2,846

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 - Investigating
There have been data quality concerns raised with indicator



Place Team	Performance	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	29.0%	197	679	65%	Concern	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	21.8%	298	1,369	65%	Normal Variation	Consistently Off Target
Specialist Care Group (No Place Team)	32.2%	38	118	65%	Improvement	Consistently Off Target
Sunderland & South Tyneside Place Team	20.2%	137	680	65%	Normal Variation	Consistently Off Target

Feedback

What the chart tells us

Performance decreased to 23.5% in March.

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, this is impacted by the capacity to allocate patients keyworker, which effects the ability to allocate new patients
- There are several patients waiting over 4 weeks to start treatment, this impacts new referrals which are waiting.
- Data quality is improving.

Improvement Actions

- A significant amount of work is underway to embed the methodology. All dashboards and relevant metrics have been updated to reflect the changes along with the proformas to allow teams time to review and correct data if applicable.
- Fortnightly waiting list meetings overseen by each team.
- Bi-monthly Access Oversight Group established with CBU's reporting back monthly to the Access Oversight Group.
- Action plans in place to address all those showing as waiting over 104 and over 78 weeks. All people have been seen but require an element of recording to be updated.

Expected impact and by when

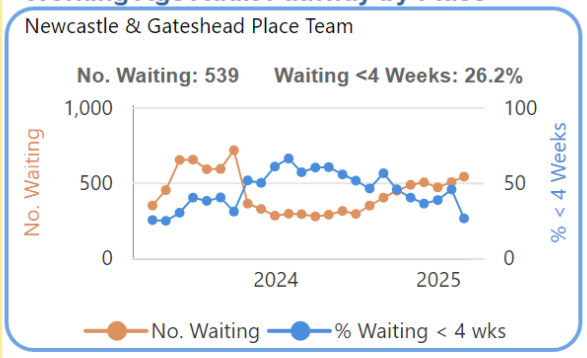
It is expected that performance continues to improve throughout 2025
Over 104 weeks have reduced from 40 to 22 in March
78 – 103 weeks waits have reduced from 38 – 31 in March
52 – 77 weeks waits have reduced from 80 to 76 in March.

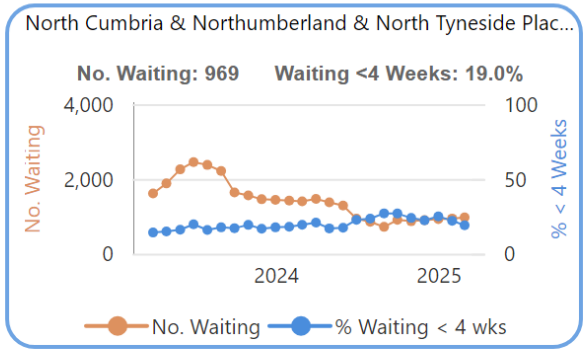
Working Age Adult and Older People Waits

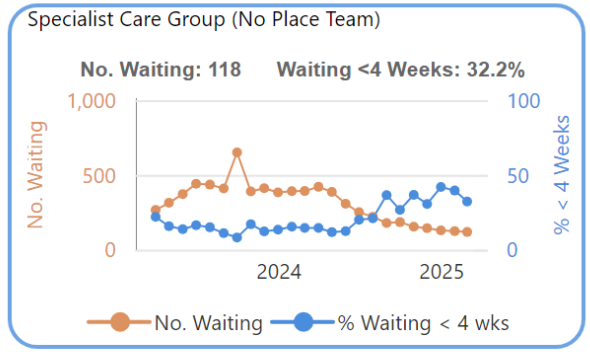
Reporting Period: Mar 2025

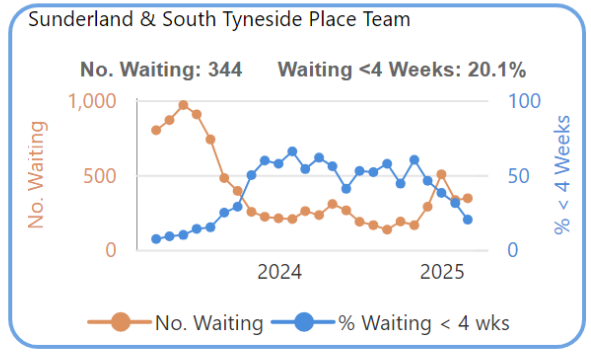
Pathway	Place Team Name	0-51 Weeks	52-77 Weeks	78-103 Weeks	Over 104 Weeks	Total
WAA	Newcastle & Gateshead Place Team	539	0	0	0	**539**
	North Cumbria & Northumberland & North Tyneside Place Team	843	74	30	22	**969**
	Specialist Care Group (No Place Team)	117	0	1	0	**118**
	Sunderland & South Tyneside Place Team	343	1	0	0	**344**
	Total	**1,842**	**75**	**31**	**22**	**1,970**
OPS	Newcastle & Gateshead Place Team	140	0	0	0	**140**
	North Cumbria & Northumberland & North Tyneside Place Team	399	1	0	0	**400**
	Sunderland & South Tyneside Place Team	336	0	0	0	**336**
	Total	**875**	**1**	**0**	**0**	**876**
Total		**2,717**	**76**	**31**	**22**	**2,846**

Working Age Adult Pathway by Place

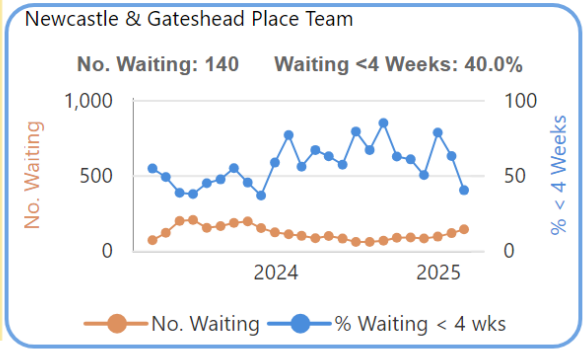


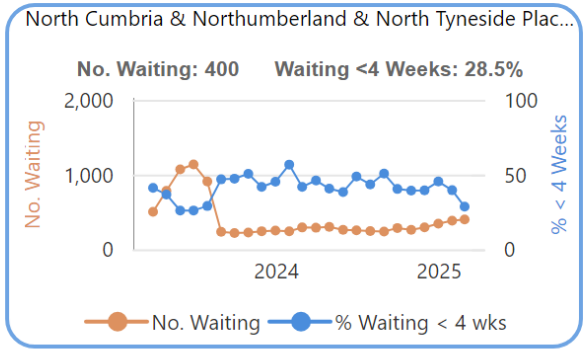


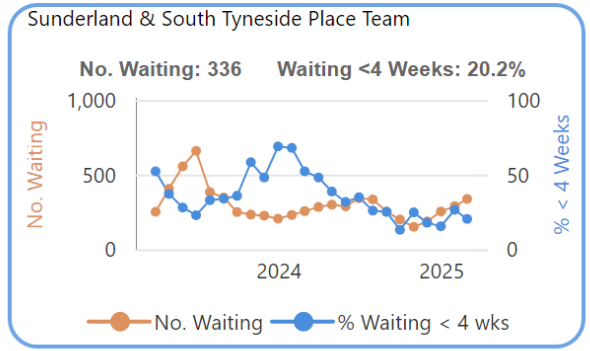




Older People Pathway by Place







A11 % Waiting 4 wks or less to receive help (CYPS)

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

Risk Rating: High (Action)

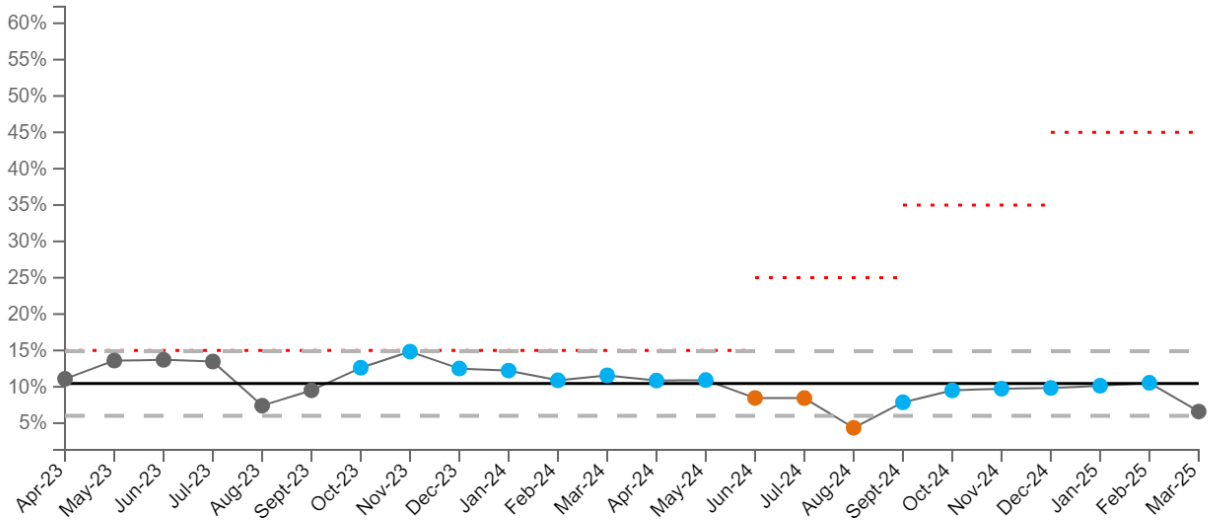
tgt. = target n. = numerator d. = denominator

6.6%	tgt.	45%
	n.	615
	d.	9,313

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 - Investigating
There have been data quality concerns raised with indicator



Place Team	Performance	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	5.0%	342	6,789	45%	Normal Variation	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	10.0%	176	1,754	45%	Normal Variation	Consistently Off Target
Specialist Care Group (No Place Team)	4.2%	25	594	45%	SPC n/a	SPC n/a
Sunderland & South Tyneside Place Team	40.9%	72	176	45%	Concern	Achieve at Random

Feedback

What the chart tells us

6.6% of referrals have been waiting 4 weeks or less to receive help. The 45% trajectory for Q4 has not been achieved.

Root Cause of the performance issue

- Waits are predominantly within the neurodevelopmental pathways with increased demand on the pathway.
- We are now using and reporting on the under 18 methodology across all in scope services, this impacted the number of referrals included, several teams have now been added to the methodology which also looks at those patients who were under 18 when the referral was received.

Improvement Actions

- Funding has been received to support the neurodevelopmental pathway, the mobilisation and recruitment is now underway, this funding will increase the capacity within the pathway.
- To improve data quality, work has commenced with the additional new teams included, due to the methodology change, to ensure they understand what the methodology is and to review their recording options and practices in RiO including the use of appropriate outcome measures.
- Inclusion of those additional patients who were under 18 when the referral was received has had a positive impact on the figures.
- Initial assessment calls in SPA have commenced for neuro referrals in Newcastle and Gateshead

Expected impact and by when

There is growing national attention on neurodevelopmental pathways, highlighting the significant demand for diagnoses and how we address neurodevelopmental needs. It is anticipated that this demand will persist throughout 2025. While efforts to address the issue are expected to help reduce the increasing wait times, a complete reversal of the trend is unlikely due to the ongoing demand for neurodevelopmental services, the ADHD services are working on agreeing an improvement trajectory in line with the additional funding received.

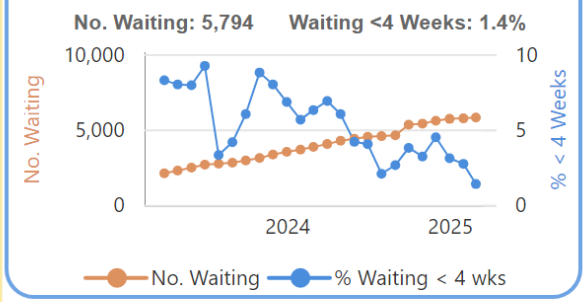
CYPS Waits by Pathway

Reporting Period: Mar 2025

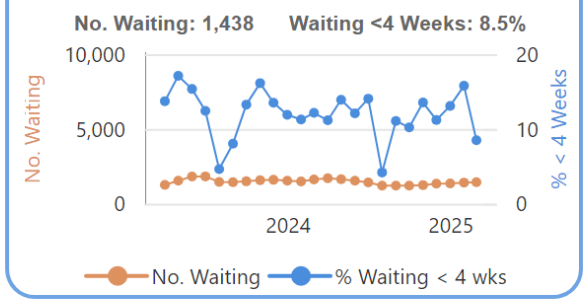
Pathway	Place Team Name	0-51 Weeks	52-77 Weeks	78-103 Weeks	Over 104 Weeks	Total
Neurodevelopmental	Newcastle & Gateshead Place Team	2,016	1,386	850	1,542	**5,794**
	North Cumbria & Northumberland & North Tyneside Place Team	813	199	217	209	**1,438**
	Specialist Care Group (No Place Team)	3	0	0	0	**3**
	Sunderland & South Tyneside Place Team	49	1	15	0	**65**
	CNTW	**2,881**	**1,586**	**1,082**	**1,751**	**7,300**
Mental Health & Learning Disability	Newcastle & Gateshead Place Team	876	21	21	77	**995**
	North Cumbria & Northumberland & North Tyneside Place Team	179	21	14	102	**316**
	Specialist Care Group (No Place Team)	173	7	0	411	**591**
	Sunderland & South Tyneside Place Team	86	11	10	4	**111**
	CNTW	**1,314**	**60**	**45**	**594**	**2,013**
All Pathways		**4,195**	**1,646**	**1,127**	**2,345**	**9,313**

Neurodevelopmental Pathway by Place

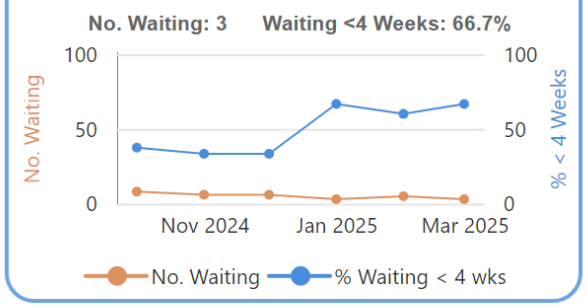
Newcastle & Gateshead Place Team



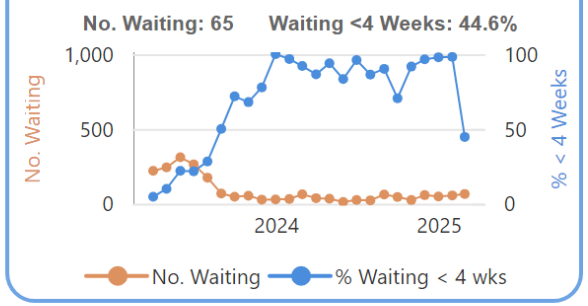
North Cumbria & Northumberland & North Tyneside Plac...



Specialist Care Group (No Place Team)

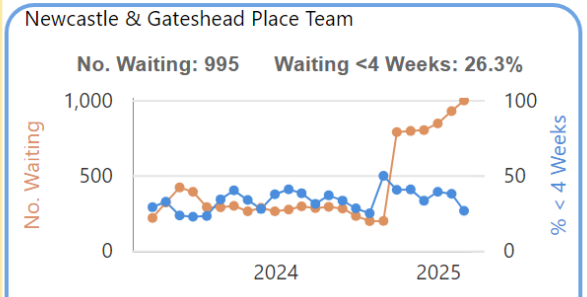


Sunderland & South Tyneside Place Team

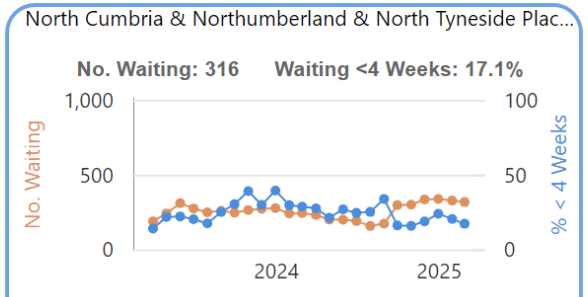


Mental Health & Learning Disability Pathway by Place

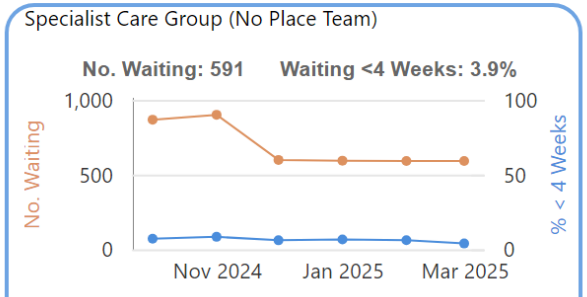
Newcastle & Gateshead Place Team



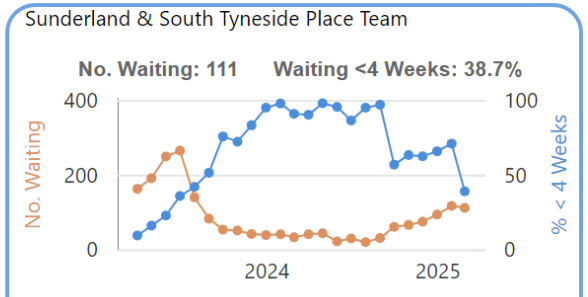
North Cumbria & Northumberland & North Tyneside Plac...



Specialist Care Group (No Place Team)



Sunderland & South Tyneside Place Team



Meeting	**Board of Directors**		**Agenda item: 1.5**
Date of meeting	**30th April 2025**		
Report title	**Integrated Performance Report (IPR) Period: March 2025**		
Report Lead	**Ramona Duguid, Chief Operating Officer**		
Prepared by	**Tommy Davies, Deputy Director of Transformation, Delivery and Performance**		
Purpose	**For decision**	**For assurance**	**For awareness**
		☑	☑
Report previously considered by	Executive Management Group – 28th April 2025		
Executive summary	The report for the final month of the year includes additional updates on how the monthly and quarterly reporting will be further developed for 25/26 in line with the updated Board schedule for the coming year. Work will be progressed with Board Committee Chair's to ensure committee reporting supports the quarterly reporting to Board on key trends and matters for escalation. The report also includes the new national performance metrics which the Trust will be measured against for 2025/26. Work is being carried out now on the draft metrics and the Trust's draft performance against these. These measures will directly link to the NHS national oversight framework segmentation and will be reported to the Board quarterly during 25/26. **Positive highlights for Month 12** • **How was the care we provided –** Reported above target for the first time in 12 months • **Do you feel safe? –** reported consistently above target for 12 months. • **Training Courses –** 9 of the 11 all staff training course are on target. Local Induction and Web Risk Register training remain off target. • **Clinical Supervision** – Reported at 81.3% as at 31/03/25 above the 80% target • **MRE Restraints** – Lowest position reported in 24 months. • **Psychiatric Liaison seen within Ward in 24 hours** – Continues to be reported above target. • **EIP Starting treatment in 2 weeks** – Reported consistently above target. A detailed summary is also included on the position of Prone Restraints/Assaults on Patients/self-harm in the IPR to ensure focus		

	remains on these important metrics across the Trust. **Areas of concern and where recovery plans are in place** • Clinically Ready for Discharge & bed occupancy. • Active Inappropriate Out of Area Placements. • Crisis Very Urgent (4 hours) and Urgent (24 hours) Referrals • Neurodevelopmental waits for children and young people and adults. • Capacity recording – rights at point of detention.
Detail of corporate/ strategic risks	**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 **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 **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 **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
Recommendation	To note the performance position and seek assurance on the recovery plans in place on areas of underperformance.
Supporting information / appendices	Not applicable

2. STRATEGIC AMBITION 1 - QUALITY CARE, EVERY DAY

Darren Best, Chair

2.1 QUALITY AND PERFORMANCE COMMITTEE QUARTERLY ASSURANCE REPORT

Louise Nelson, Committee Chair

REFERENCES

Only PDFs are attached

2.1 Quality and Performance Committee Assurance report to Board - April 25.pdf

Report to the Board of Directors
30 April 2025

Quality and Performance Committee Quarterly Assurance Report
Quarter 4 report (January 2025 – April 2025)

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the Quality and Performance Committee. This includes an overview of the areas of focus, discussion and assurance and the Board Assurance Framework risks currently aligned to the Committee.

2. Quality and Performance Committee overview

The Committee receives assurance on the implementation and delivery of key performance, quality, safety strategies, programmes of work and systems. It also has oversight of patient and carer experience, including continued the focus on ensuring patient and carer involvement is embedded across the Trust. The Committee receives assurance in relation to systems and processes to ensure ongoing compliance with legislative frameworks including the Care Quality Commission, NICE guidance and other nationally agreed guidance relating to Clinical Effectiveness.

A representative from the North East and North Cumbria Integrated Care Board also attends meetings of the Committee. There have been two meetings of the Committee during the period January 2025 – April 2025. Meetings were held on 29 January and 9 April.

3. Board Assurance Framework risks within Committee remit

The Quality and Performance Committee is currently managing the following key risks on the BAF:

Risk No.	Risk descriptor	Risk score
Risk 2510	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.	4 (likely) X 4 (significant) 16
Risk 2511	Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.	3 (possible) X 5 (major) 15
Risk 2512	Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern.	3 (possible) X 4 (significant) 12
Risk 2543	Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services.	3 (possible) X 4 (significant) 12

4. Quality and Performance Committee focus January – April 2025

4.1 Assurance relating to risk 2510

This is predominantly received through the Integrated Performance Report which provides a summary of all performance metrics for the period. During the period, this has been supported

with bespoke reports on key areas of focus including the work to reduce waiting times, challenges in crisis Services, the work of the violence reduction group, and the improving performance related to reducing restrictive practice. A detailed review of those patients Clinically Ready for Discharge (CFRD) who have been in services for a significant period of time was also discussed. Although bespoke, detailed reports have been received, the Committee recognise that this will be a dynamic process, and regular meetings take place with Executive Leads to discuss Committee papers to establish the need for additional areas of scrutiny to be identified.

4.2 Assurance relating to risk 2511

In January, an update on the Operational Pressure Escalation Level (OPEL) Framework was presented. This is a key component of emergency preparedness, resilience and response requirements which supports local Integrated Care Systems (ICS) and provides a national measurement of NHS system pressure. Mental health core measures have recently been added to ensure visibility across the system.

Regular Safer Staffing reports are reviewed by the Committee and national benchmarking confirms the Trust is a significant outlier in terms of inpatient services in relation to the heavy reliance and use of unqualified staff. Ongoing work relating to the enhanced multi-disciplinary team approach will go some way to addressing this issue in the coming months. Work is also being undertaken with Tees, Esk and Wear Valley NHS FT to review and compare inpatient staffing levels. The outputs from this will be fed back to the Committee and the NENC ICB.

The Committee continues to receive CQC Compliance updates and review Must Do actions. The Committee approved the closure of a Must Do action in relation to MRE/debrief compliance within Child and Adolescent Mental Health (CAMH) wards, on the basis of the level of assurance provided that the use of MRE across CAMH wards continues to reduce with compliance rates in relation to ensuring that debriefs are carried out following an instance of MRE is at 100%. There are eight remaining must-do actions.

The Committee noted that the draft report from the focussed inspection of Learning Disability and Autism wards during July 2024 had been received for factual accuracy checking. A publication date of the final report is currently awaited.

A three-day CQC inspection of community adult mental health teams and early intervention in psychosis teams was undertaken in February across all localities. High level feedback was provided which included positive areas of practice as well as areas for improvement which included staffing pressures, supervision and training, completion of care plans and risk assessments and the impact of the GP collective action. Once received, the final report will be submitted for review and discussion.

The bi-annual report on NICE guidance was discussed confirming a strong system for Trust assessment against the guidance. Areas of non-compliance were reported in relation to violence and aggression and the report detailed mitigations in place. The Committee noted some elements of the guidance where further clarification was required in relation to the assurance level in some areas of practice and in the context of the age of the guidance not meeting the pace of development and change within the NHS.

4.3 Assurance relating to risk 2512

is predominantly received through regular reporting of serious care reviews and independent investigations. The reports include learning from incidents and cases both locally and from a multi-organisational perspective.

In line with the national Patient Safety Incident Response Framework, the Committee receives and reviews all Patient Safety Incident Investigations (PSII). Three reports have been received during the period. The Committee approved the PSII outcome reports in terms of process and although learning was evident in all reports, the Committee will continue to review the ongoing, longer-term impact of the learning.

The Committee also reviews publication of independent reports from other providers and organisations and during the period, the Committee have received an update on areas of learning from a CNTW perspective from reports. During the period, a review of potential learning from the publication of the TEWV assurance review was discussed.

A presentation was delivered to the April meeting on the ongoing work in relation to sexual safety across the Trust and the national guidance which provides the standards and expectations for practice. The importance of recognising issues of sexual safety was noted as one of the key drivers behind a number of service developments this year, for example the Case for Change for acute adult inpatient services in West Cumbria in terms of the safety issues relating to mixed-sex wards. A communications and engagement plan is in development for roll-out across the Trust. The Committee received the quarterly Quality and Safety report in January which focuses on learning from incidents, restrictive practice, safeguarding and public protection and complaints and claims. There were no significant issues of concern to note.

4.4 Assurance relating to Risk 2543

There were no reports on the holistic overview of the work of the Trust transformation programmes and the development of the Model of Care given the strategic nature of this and the responsibilities of all Committees, Executive Management Group, operational Groups and the Board. However, the Committee recognises that the cycle of business as it currently stands, and key areas of focus continue to reflect the actions required, within the Committees remit to enable delivery of the Model of Care in the longer-term.

4.5 Other issues and assurance received by the Committee

The Committee received the service user and carer experience report and the refresh of the Together Strategy – a strategy developed by the Service User and Carer Reference Group. Although the Trust has a great deal to be proud of in terms of its approach to involvement of service users and carers, there is recognition both at Board and Committee level, that there is much work to do to ensure involvement is fully embedded within, and across the whole organisation.

The Committee received reports and evidence of full assurance in relation to:

- Controlled drugs management and use internal control and assurance
- Medicines optimisation internal control and assurance
- Caldicott and health informatics internal control and process
- Infection Prevention and Control Assurance
- Clinical audits internal control and assurance
- Trust draft Quality Priorities

5. Ongoing areas of focus for the Committee

As well as standing items for regular review, the Committee will undertake specific oversight and review of the continuing work to reduce the use of restrictive practice, approaches to managing, reporting and supporting incidents of self-harm, a review of the learning from the Shanley independent review into the care and treatment provided by Greater Manchester Mental Health

NHS Foundation Trust and the safer staffing review and work with TEWV. Time will also be allocated to a further update on violence and aggression in July.

Summary and recommendation

The Quality and Performance Committee has continued to ensure alignment of the cycle of business with the Board Assurance Framework and ensuring the continued focus on assurance of the actions being taken to address key risks to achieving the Trusts Strategic Ambitions.

The Board is asked to note the content of the report and seek further assurance on any issues where appropriate.

Louise Nelson
Chair of Quality and Performance Committee
April 2025

2.2 MENTAL HEALTH LEGISLATION COMMITTEE QUARTERLY REPORT

Michael Robinson, Committee Chair

REFERENCES

Only PDFs are attached

2.2 MHLC Committee Assurance report to Board - April 25.pdf

Report to the Board of Directors
30 April 2025

Mental Health Legislation Committee Quarterly Assurance Report
Quarter 4 report (January 2025 – April 2025)

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the Mental Health Legislation Committee. This includes an overview of the areas of focus, discussion and assurance.

2. Mental Health Legislation Committee overview

The Committee receives assurance that there are systems, structures and processes in place to ensure compliance with, and support to, the operation of Mental Health Legislation within inpatient and community settings. It ensures that any proposed changes to Mental Health Legislation are identified and monitored, and necessary changes made to practice comply with associated codes of practice and recognised best practice.

It ensures the Trust has in place and uses appropriate policies and procedures in relation to Mental Health Legislation and to facilitate the publication and guidance of the legislation to all relevant staff, service users, carers and managers.

There have been two meetings of the Committee during the period January 2025 – April 2025. Meetings were held on 31 January and 11 April.

3. Board Assurance Framework risks within Committee remit

There are no Board Assurance Framework risks aligned to the Committee at the current time. The Committee has reviewed the need for a risk relating to the impact of the changes to the Mental Health Bill. The Committee felt at present, risks associated with this were being managed at the most appropriate level in the organisation but have agreed to regular review this on an ongoing basis.

4. Mental Health Legislation Committee focus January – April 2025

The Committee discussed the appraisal process in relation to panel members. Documentation has been developed to strengthen the process and provide clarity. Assurance was provided that recruitment, and training of, panel members remained in a strong position and active recruitment from ethnic minority communities remains ongoing.

In response to outstanding Must Do actions, the Committee received an update on the work in relation to strengthening the care planning process and guidance. This has been undertaken through workshops comprised of multi-disciplinary leads with service users, carers and support from the Digital team. An update on the outcome of the work will be provided to the April meeting of the CQC Compliance Group.

The Committee discussed the ongoing issue relating to completion of Part A and Part B compliance and the potential impact of transfers. Following an internal audit in relation to the compliance and quality, the form will now be reviewed to simplify and separate Part A and Part B into an individual form. In terms of provision of additional assurance, supervision and individual feedback would be incorporated into the process. The Mental Health Legislation Steering Group

will continue to monitor the completion of Parts A and B and report to the Committee on steps taken to ensure compliance.

In February, the Committee received an update from the Health Inequalities Lead on Mental Health Act Detentions and Health Inequalities noting an increase in detention rates over the past three years and queried the link to ethnicity. It was recognised that the population of minority communities had increased in the North East however, there is a lack of high quality data in this regard. A further discussion will take place to review other indicators in this regard.

The Committee were pleased to note compliance rates associated with Mental Health Legislation Training continued to increase.

5. Ongoing areas of focus for the Committee

Confirmation of the final agreed process in relation to appraisal of panel members will be reviewed at the June meeting of the Committee.

Confirmation of the outcome of the work to strengthen the care planning process and guidance associated with an outstanding CQC Must Do action will be reviewed at the June meeting.

Further assurance will be received at a future meeting in relation to data on compliance with the giving of rights in relation to Community Treatment Order.

The Committee will continue to monitor closely the compliance with completion of Parts A and B.

It was agreed that the Committee would receive the Corporate Risk Register, the highest-level operational risks within the Trust to provide additional assurance of any Trust risks in relation to Mental Health Legislation.

The Committee will keep under review data quality in relation to health inequalities and the link to mental health detentions. This will be incorporated into the overall health inequalities work.

Summary and recommendation

The Mental Health Legislation Committee has continued to ensure focus on assurance of the actions being taken to address key issues in achieving the Trusts Strategic Ambitions.

The Board is asked to note the content of the report and seek further assurance on any issues where appropriate.

Michael Robinson
Chair of Mental Health Legislation Committee
April 2025

2.3 CARE QUALITY COMMISSION - LEARNING DISABILITIES AND AUTISM SERVICES REPORT

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

2.4 TRUST LEARNING FROM THE INDEPENDENT MENTAL HEALTH HOMICIDE REPORT INTO THE TREATMENT OF VALDO CALOCANE

Rajesh Nadkarni, Deputy Chief Executive and Medical Director

REFERENCES

Only PDFs are attached

2.4a Learning from Independent Homicide report VC 30.04.25..pdf

2.4b VC Action Plan Response as of 14.04.25. FINAL.pdf

Meeting	**Board of Directors**		**Agenda item: 2.4**
Date of meeting	**30th April 2025**		
Report title	**Trust Learning from Independent Mental Health Homicide Report into the treatment of Valdo Calocane**		
Report Lead	**Rajesh Nadkarni, Medical Director / Deputy Chief Executive**		
Prepared by	**Rajesh Nadkarni, Medical Director / Deputy Chief Executive**		
Purpose	**For decision**	**For assurance**	**For awareness**
		X	x
Report previously considered by	Trustwide Safety Group 15 April 2025 To be discussed at the Executive Management Meeting 28 April 2025		
Executive summary	The independent mental health homicide report into the treatment of Valdo Calocane was published by NHS England on 5 February 2025. The aim of the investigation was to thoroughly review the NHS care and treatment provided to Valdo Calocane by Nottinghamshire Health Care NHS Foundation Trust prior to the tragic events on 13 June 2023, and the interactions the NHS had with other agencies involved in his care. The review identified clear failings in the care and treatment provided to Valdo Calocane and produced a series of recommendations for Nottinghamshire Health Care NHS Foundation Trust and NHS England. It followed the Care Quality Commissions special review of Mental Health Services at the Trust. NHS England has previously required provider organisations and the system to learn from the incident and to specifically improve intensive and assertive community treatment for people with serious mental illness. Following the publication of this report NHS England has asked NHS Trusts and the Integrated Care Boards to review their current improvement plans with particular attention to: • Personalised assessment of risk across community and inpatient teams • Joint discharge planning arrangements between the person, their family, the inpatients and community team (alongside other involved agencies) • Multiagency working and information sharing • Working closely with families • Eliminating out of area placements Updated action plans have been asked to be discussed in both Trusts and ICB meetings no later than 30 June 2025. Trustwide Safety Group (TSG) has oversight of coordinating and managing the actions arising from the independent review and previous reviews carried out by the CQC. Since the publication TSG has influenced a range of work which culminated into a finalised action plan which was discussed and agreed		

	on 15 April 2025. There is a planned further discussion at the Executive Management Group meeting this month. The action plan incorporates recommendations from all reports into Valdo Calocane's care and is included in the papers of the Board for information. It is planned that the milestones for improvement within the plan will be monitored through business delivery group (quality) within the Trust Governance structures. Regular feedback will be incorporated to assure the Board through the Quality and Performance Committee of our progress.
Detail of corporate/ strategic risks	Board Assurance Framework – 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.
Recommendation	To seek Board views about the suitability of the plan and any suggestions for further assurance.
Supporting information / appendices	VC Action Plan Response as of 14.05.25 - final

Action Plan for CNTW response to the recommendations Independent and CQC reports into the care and treatment of VC and NHFT.

	Theme	Action	Lead	Update on Status of Actions Taken and Improvements Identified for future
1.	Care Delivery providing effective evidence based and safe care to those with severe mental illness	• Ensure assertive engagement and intensive case management of those with severe mental illness • Delivery of evidence-based treatments • Progress moving away from CPA	Anna English, Group Director	Intensive and Assertive Management Identification of the cohort requiring assertive management completed. Review of their care in localities over the next 3 - 6 months. Policies and guidance to support disengagement in place. **Evidence Based Treatment** **Pharmacological** Recruitment for non-invasive blood testing initiated to monitor Clozapine in community team to provide community Clozapine service to be completed in 6 months along with clinical governance protocols to support. Estates work to expand community pharmacy to support a wider roll out of the service and include other treatment in 2026. **Psychological** Analysis of skills and capacity complete and plans to improve capacity in teams over the next 12 months. Brief evidence based psychological interventions rolled out in

				most community teams. **Moving Away from CPA** Operating framework for Key Worker role and MDT responsibilities in decision making completed. To be tested out in two pilot aeras in the Trust commencing in Cumbria, Northumberland in June 2025.
2.	Risk assessment and management	• Review of current clinical risk assessment and management process • Review appropriateness of risk of harm approaches • Multiagency risk management arrangements	Sarah Brown, Group Medical Director Uri Torres, Associate Medical Director Claire Thomas, Deputy Director of Safer Care	**Risk Assessment** On 8 April 2024, the Trust launched a new biopsychosocial risk assessment framework linked to safety planning across all services. This new biopsychosocial risk framework now highlights the need for staff to consider future changes which may affect a patient's risk assessment and is therefore dynamic in its approach. Policies, and relevant training have been implemented and new documentation to support recording has been developed in our RIO electronic patient care record. This includes close attention to safety planning and involvement of family and carers. There is ongoing work to assess the quality of the documentation and further work to focusing on the appropriateness of the risk of harm approaches. **Multiagency risk management arrangements**

				The Trust actively contributes to statutory and non- statutory safeguarding and public protection arrangements including MARAC, MAPPA and Prevent. We have a centralised safeguarding and public protection team who provide advice and supervision for clinical teams in safeguarding our patients and others. We have a Police liaison clinical lead who works with Police forces across the Trust footprint to supporting joint working on individual cases and assists in developing joint procedures, guidance and opportunities for reflection and learning. Clinical teams also co-ordinate and attend multiagency meetings for cases where there is complexity and benefits from a multi-agency approach.
3.	Family and carer engagement	• Patient Carer Race Equality Framework Progress (**PCREF**) • Progress on family and carer engagement including embedding of triangle of care.	Lynne Shaw, Director of Workforce Sarah Rushbrooke, Director of Nursing and Therapies All Group Nurse Directors	**Patient and Carer Race Equality Framework (PCREF)** Co-produce systematic approach to involving patients, carers, families and communities from minoritised backgrounds in making our services anti-racist and culturally competent. Co-production phase April-Sep ’25 with new engagement structures in place by March ’26. **Engagement with Families and Carers** All Care groups have Lived Experience Groups which is supported by the Involvement and Lived Experience Team. The new Together Strategy was launched at Service User and carer reference group on 10th April 2025.

				Achievements/what is working well (aligned to the six principles): 1. Introduction of carers cards 2. Co-production of staff carers awareness training 3. Supporting service users to complete recovery plans 4. Continuing to develop and employ people into carer dedicated roles 5. Carer conference/co-produced carer resources/carer noticeboards/carer champions and specific carer leaflets 6. Carer forums/partnership working/carer record/getting to know you as a carer/Staff carer support group Future planned actions include Trust Care groups being required to evaluate performance against six principles and to develop a dashboard.
4.	Multiagency clinical information sharing	• Review current approach to clinical and risk related patient data in electronic patient record systems and communication to partners including primary care	Angela Faill, Associate Director Information Governance & MH Legislation Jonathan Richardson, Chief Clinical Information Officer Mike Jones, Associate Chief Clinical Information Officer	New risk assessment framework makes it easier for us to communicate information to our partners through the Great North Care Record. Next steps involve assessing the precise processes and system performance impact before it can be activated, over the next 3 months.
5.	Multiagency working	• Review current arrangements with ICB	Rajesh Nadkarni, Medical Director / Deputy Chief	Sarah Rushbrooke meeting with the ICB Chief Nurse in 14th April to discuss quality governance with the ICB and CNTW.

		and other relevant partners e.g. Police	Executive Sarah Rushbrooke, Director of Nursing and Therapies	Sarah Rushbrooke member of the ICB System Quality Group Meetings. We have regular meetings with partners through the Northumbria Police Right Care Right Person meetings. Regular formal and informal meetings bimonthly with CQC.
6.	Quality and safety governance	• Review of current systems and recommendations for improvement	Rajesh Nadkarni, Medical Director / Deputy Chief Executive Ramona Duguid, Chief Operating Officer Sarah Rushbrooke, Director of Nursing and Therapies	Quality and safety goals and priorities developed and currently undergoing a process of engagement with relevant forums. Review of current quality assurance processes ongoing to ensure embedding of learning and improvement.
7.	Policy development and review	• Reviewing clinical Trust policies to ensure that they are current updated and written in a manner which enables staff to practice in line with policy	Ramona Duguid, Chief Operating Officer Sarah Rushbrooke, Director of Nursing and Therapies Damian Robinson, Group Medical Director	Review of all policies relevant to Quality and safety to ensure that they meet the principles of being up to date, precise, and appropriate for use by clinical staff to be commenced.
8.	Peer Support	• Peer support involvement in community mental	Sarah Rushbrooke, Director of Nursing and Therapies	Mapping of all Peer Support involvement in Community services has been undertaken by the Lived Experience Service

		health services for those with severe mental illness and which is culturally appropriate		Team (LES) in March 2025 identifying areas for improvement. Recommendations have been shared with the Community care group and the LES team are working with the group to address the gaps and cultural aspects.
9.	Care Planning	Coproduction of care plans	Sheree McCartney, Group Nurse Director Elaine Fletcher, Group Nurse Director Lisa Strong, Deputy Director of Nursing and Therapies	Over the past year, a dedicated group under the leadership of group nurse directors have looked at the personalised care planning process, ensuring coproduction, and care plan discussion at each point of a patients care and treatment. Electronic Patient Record has been updated allow for guides to support staff to be able to work with patients to develop their care plans. Outputs from that work continue to be progressed and monitored.
10	Joint clinical decision making between inpatient and community services	Review systems to ensure that those admitted to inpatient adult wards have ongoing engagement of community services who also have an influence in inpatient care and decision making	Sarah Brown, Group Medical Director Neeraj Berry, Group Medical Director	Inpatient and Community Medical Directors are to improve interface working and communication. A task and finish group is proposed to develop shared actions and it is anticipated to recommend actions for implementation over the next 3 months.

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

Darren Best, Chair

3.1 WEST CUMBRIA STRATEGIC CASE FOR CHANGE - FOR APPROVAL

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

3.1a. Strategic Case for Change - West Cumbria Exec Summary.pdf

3.1b. Strategic Case for Change - West Cumbria - Full Case.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 3.1**
Date of meeting	Wednesday 30 April 2025		
Report title	Strategic Case for Case – Improving quality and sustainability in mental health services in West Cumbria		
Report Lead	Ramona Duguid, Chief Operating Officer		
Prepared by	Ramona Duguid, Chief Operating Officer		
Purpose	**For decision**	**For assurance**	**For awareness**
	X		
Report previously considered by	Resource and Business Assurance Committee – 11 April 2025 Executive Management Group – 31 March 2025 North East and North Cumbria Integrated Care Board Executive Committee – April 2025		
Executive summary	This strategic case for change outlines the proposal to improve the quality and sustainability of mental health services in West Cumbria through the development of innovative and nationally leading community services and the consolidation of inpatient adult acute beds onto the Carleton Clinic site in Carlisle. These changes are aimed to address long standing quality, safety and sustainability issues in the delivery of adult acute inpatient services currently provided at Yewdale Ward in Whitehaven, which is the only mixed sex adult acute admission ward in the Trust and is the only stand alone acute admission ward in the Trust. Operational changes in how the unit admits patients have been made over the last two years to mitigate some of these concerns however the inability to recruit and retain key positions leaves the ward in an unsustainable position. The case for change outlines the reprovision of these adult acute beds onto the Carleton Clinic site in Carlisle. The case for change aligns to our Strategic Ambition of 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 which supports the national drivers of illness to prevention and hospital to community care. Discussions with partners and the North East and North Cumbria Integrated Care Board (NENC ICB) have taken place over the last 18 months to gain momentum for the longer-term direction of travel, particularly for isolated mental health inpatient units, which includes Yewdale Ward. Public, staff and stakeholder engagement on this Case for Change formally commenced in October 2024. The engagement process ran until 25 January 2025 and the outcome of that process was presented to the Board of Directors in February and is available here. The Board recognised the level of engagement activity which included face to face listening events for local communities and partner organisations in West		

Cumbria and Carlisle, online listening events, an online survey, use of social media, individual and collective discussions with staff. The Chief Executive and executive directors have formally met with Cumberland Council's Health Overview and Scrutiny Committee.

To add an additional layer of independence to the process, the Trust commissioned People First to undertake discussions with people with lived experience of the services and local experience. People First were also commissioned to undertake an independent analysis of the online survey feedback.

Common themes were highlighted in all elements of the engagement activity. This included the importance of recognising concerns relating to support for families and carers in relation to travel and transport to visit loved ones, recognition of the challenges of social care crisis and community support, and the role of the new Hope Haven 24/7 community hub in Whitehaven.

The feedback from the engagement activity has provided the Trust with key themes which are being progressed as part of existing work across community services. These include; how Hope Haven, the new 24/7 hub will work in practice, how workforce skills can be retained in Whitehaven, how we will support third sector organisations to thrive and how outcomes for mental health care will be improved over the longer term.

It is important to add that the long-standing concern from the local community on moving services away from Whitehaven was also received during the engagement process. The Trust has been open and transparent about the safety and quality risks facing Yewdale Ward along with the inability to achieve a sustainable and safe staffing model for this stand-alone, mixed sex adult acute admission ward.

Further work on the broader health outcomes for the local population, including the work on suicide prevention is needed with partners, however the viability of Yewdale Ward has, and will remain, a fragile inpatient service which cannot meet the needs of the national commissioning framework for adult acute mental health wards.

In light of the level of engagement activity undertaken, and the lack of further mitigations to address these significant concerns, the Board of Directors supported the recommendation that further formal consultation should not be taken forward. This decision was taken in the context of the ongoing, and increasing quality and safety concerns, and it was agreed that the further delays to the decision-making process would increase the risk to patients and staff further.

The quality and safety issues are set out in detail in this Case for Change.

The case for change has been reviewed by the Executive Management Group and the Board Committee for Resources and Business Assurance Committee (RABAC).

RABAC was supportive of the case for change and requested additional detail on the income and expenditure changes across all of the inpatient based services in North Cumbria. The Committee also requested additional detail on the risks posed with not supporting the Case for Change, which have been added to this executive summary.

As part of the changes to services requirements, the Trust have engaged with the NENC ICB and have received the statement below:

	"We have met with the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust regularly over recent months regarding the need to make these necessary changes. We fully appreciate the importance of ensuring that any changes to acute inpatient mental health provision in West Cumbria are carefully considered and that the needs of the local population continue to be met. We also recognise that any decision taken by the Trust needs to be informed by the clinical case for change, and underpinning this must be the need for patients to have access to safe and sustainable services. With this in mind, we fully recognise the safety and quality issues outlined in the case for change. *We recognise the level of engagement the Trust has made to date with stakeholders including service users and carers, staff, third sector organisations and partners from across the system including the Health Overview and Scrutiny Committees. We have met with both Overview and Scrutiny Committees covering the Cumbria area and borders. While we await a formal response from both councils at this time of writing, subject to this, the ICB is supportive of the Trust's decision to re-provide services from Yewdale Ward to Carlisle based on the issues of quality and safety. Our support for this change has been given with a number of caveats which include:* • *Ensure continual review and oversight of quality impact assessments both at service and patient level.* • *Consideration of the impact on both North West Ambulance Service and North East Ambulance Service.* • *An ongoing commitment from CNTW to present to the ICBs service change oversight meeting to review, oversee and seek assurance on transitional arrangements.* • *Ongoing engagement with the Overview and Scrutiny Committees to provide regular updates on developments of mental health services in Cumbria.*
Detail of corporate/ strategic risks	Board Assurance Framework Risk 2543 – Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services. Corporate Risk Register 2463 – 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. The strategic case sets out a summary of the key safety and quality risks with Yewdale Ward (section 4.3) which supports the rationale in the case for change. It is important to stress that the risks of not supporting the case for change will remain and the potential to consider immediate changes to the level of provision within Yewdale Ward carries real risks due to the temporary consultant psychiatrist provision and the ability to comply with the Mental Health Act of Law. The support required for an acute admissions unit which is isolated cannot be fully mitigated against and carries real safety concerns for both staff and patients. The case for change also supports the delivery of the Trust's medium term financial plan requirements.
Recommendation	The Trust Board of Directors is asked to approve the proposal to re-provide services from Yewdale Ward to Carleton Clinic.

Supporting information / appendices	Full Strategic Case for Change – Improving quality and sustainability in mental health services in West Cumbria. Engagement outcome report available here.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Strategic Case for Change

Improving quality and sustainability in mental health services in West Cumbria

Content

1. Executive summary and purpose

This strategic case for change outlines the proposal to improve the quality and sustainability of mental health services in North Cumbria through the development of innovative and nationally leading community services and the consolidation of inpatient adult acute beds onto the Carleton Clinic site in Carlisle, by re-providing beds currently located in Yewdale Ward in Whitehaven.

These changes are aimed to address long standing issues in the delivery of mental health services across West Cumbria, including long standing sustainability and safety issues which have been faced at Yewdale Ward in Whitehaven.

The improvements and changes to community and crisis services in West Cumbria are in line with national policy frameworks for improving mental health services, specifically focusing on prevention and improving community infrastructure. They are also an integral part of a national programme to develop innovative and improved models of community care and support, with the aim for these to be developed and rolled out nationally.

The long-standing challenges and risks associated with stand alone units are referenced as part of this strategic case for change and the sustainability concerns which aim to be addressed by the changes outlined in this case for change.

In October 2024 an extensive public engagement exercise was undertaken, which concluded in January 2025. This case for change includes the outcomes from the engagement exercise and the Trust's response to these.

Engagement with staff working within the Yewdale ward has taken place. The Trust aims to avoid compulsory redundancies to ensure the retention of local skills within the Trust and to minimise any adverse economic and employment impacts within Whitehaven.

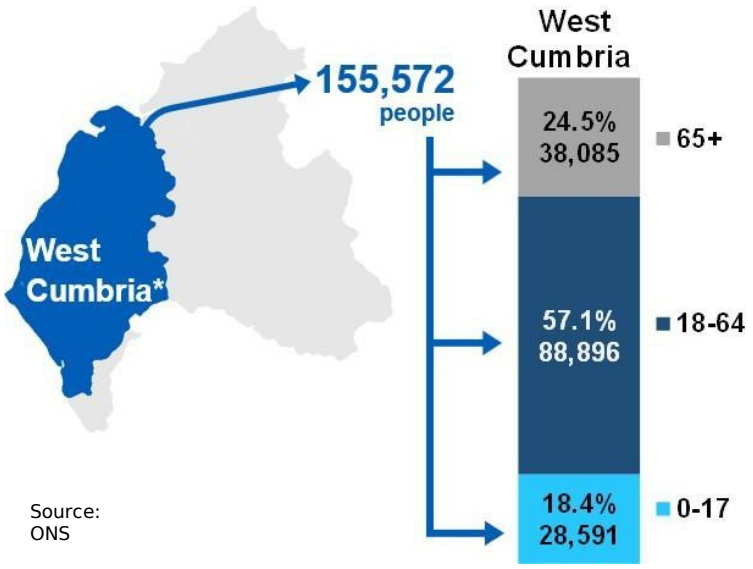
The assumptions set out in the financial analysis in this strategic case for change support the requirements of the medium term financial plan the Trust is required to deliver.

The CNTW Board of Directors have reviewed this draft case for change on 19/02/2025 and approved for this to be submitted to the North East and North Cumbria Integrated Care Board for review and approval. The ICB are requested to specifically review the public engagement which has been undertaken on these proposals and agree that further public consultation is not required on this strategic case for change and agreed with the proposals for change. This case will be considered along with the outcome from the ICB review at the CNTW public Board of Directors meeting on 30 April 2025.

2. Demographics and service provision

2.1 National demographics and population need

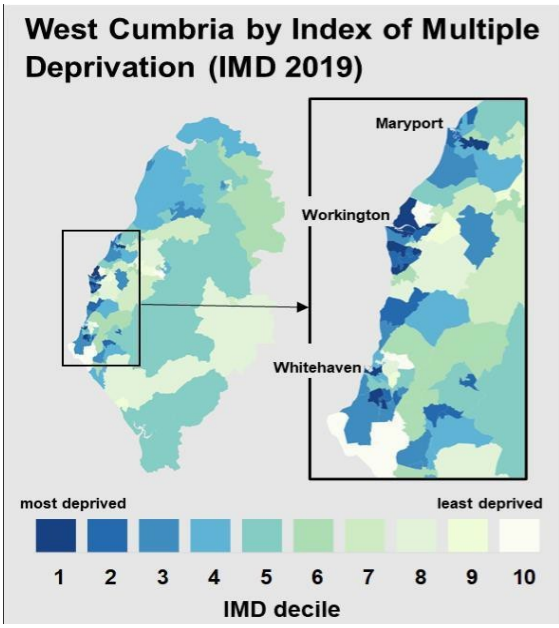
West Cumbria is located on the north west coast of England and comprises the old local authority boundaries of Allerdale and Copeland and an area of more than 760 square miles. Over half of the area is within the boundary of the Lake District National Park, and there are over 70 miles of coastline along the Irish Sea where the majority of the population resides.



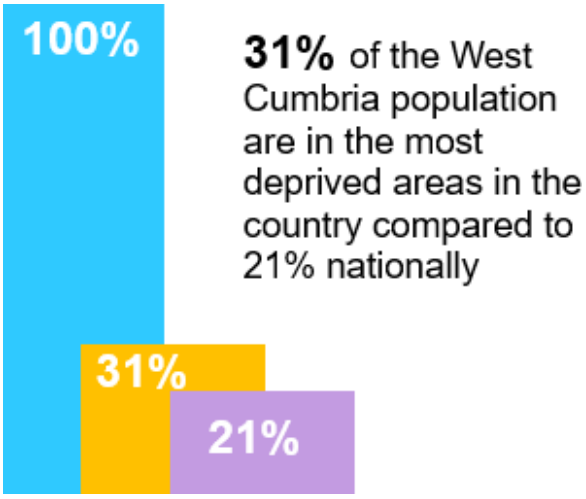
Source: ONS

West Cumbria has a relatively low population of 155,572 for its area. Predominantly rural, much of the population resides in the towns of Whitehaven, Workington, Maryport, Cockermouth, Keswick, Egremont, Cleator Moor, Frizington, Aspatria, Wigton and Silloth. The population has above the national average of people aged 65 and over.

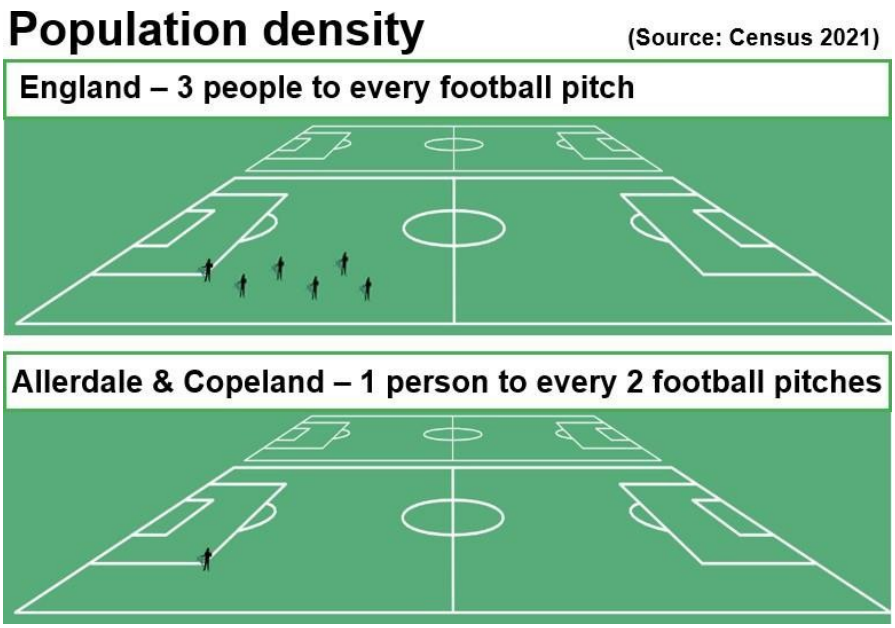
The differences between rural West Cumbria and the post-industrial areas are significant. The dominance of the nuclear sector complicates the picture, supporting with well-paid and highly skilled jobs, in contrast to the lower waged sectors of tourism and agriculture. Consequently, West Cumbria is an economically and socially diverse area where pockets of extreme deprivation exist next to affluent areas.



Source: ONS Census 2021

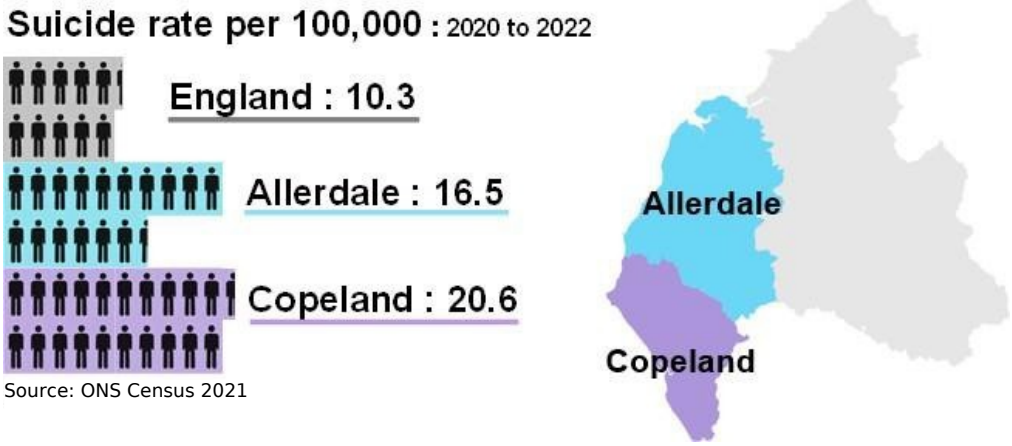


Source: ONS Census 2021



West Cumbria is a very rural area, with low population density compared to the North West and England. When communities are dispersed across a large rural area, this creates challenges for providing services that required far less frequently across a larger population such as inpatients.

Suicide rates are higher than the national average in West Cumbria with Copeland having the highest suicide rates in England.

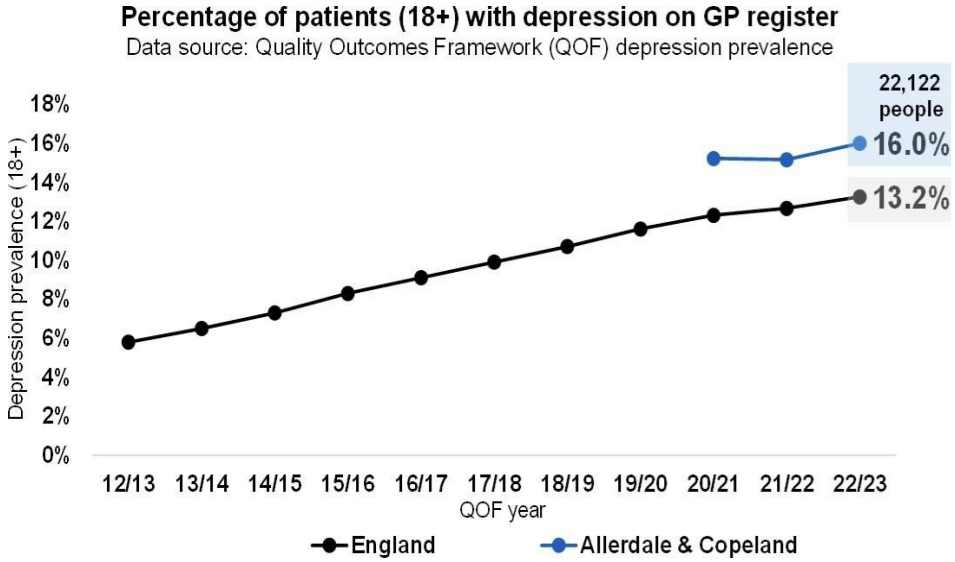


1%	16%
of the GP population has a **Severe Mental Illness (SMI)** QOF 2022/23	of the aged 18+ GP population **has a diagnosis of depression** (QOF 2022/23)
CNTW area = 1% England = 1%	CNTW area = 14.7% England = 13.2%

1% of the population have a severe mental illness and this continues to rise.

16% of the 18 and over GP population have a diagnosis of depression. This compares to 13.2% nationally and these rates have risen significantly in recent years,

Source: QOF 2022/23

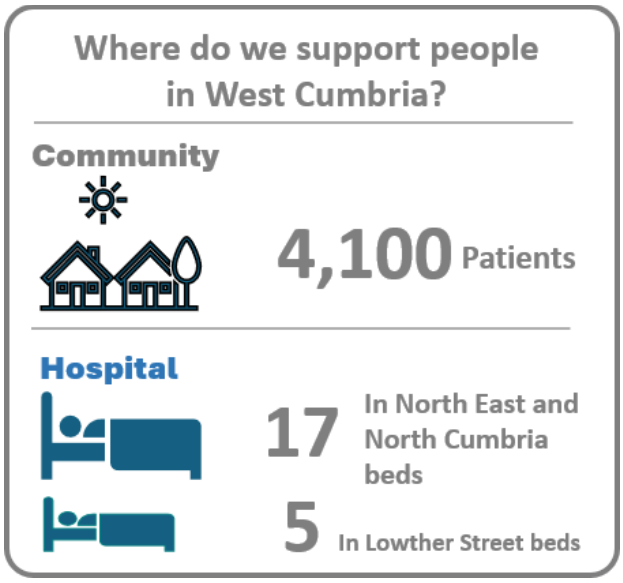


Source: QOF 2022/23

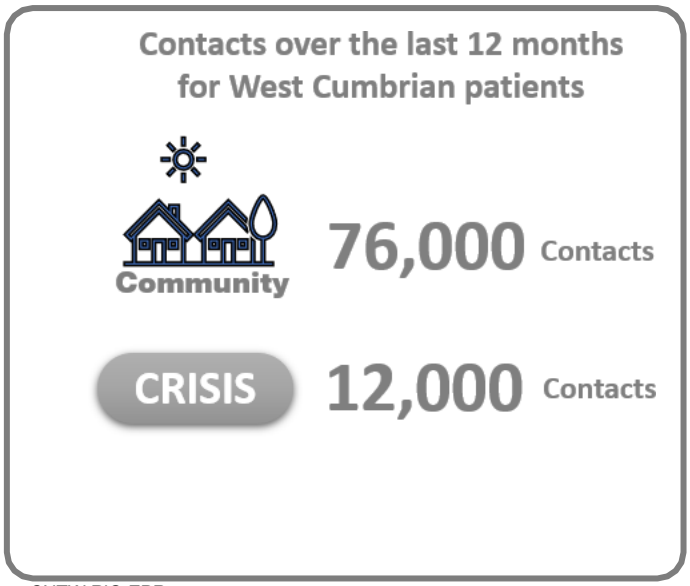
Rates of depression are on the increase across England, they are even higher in West Cumbria with 22,122 with depression on the GP register. This demands collaboration with communities and partners to support what people need.

2.2 CNTW local provision analysis

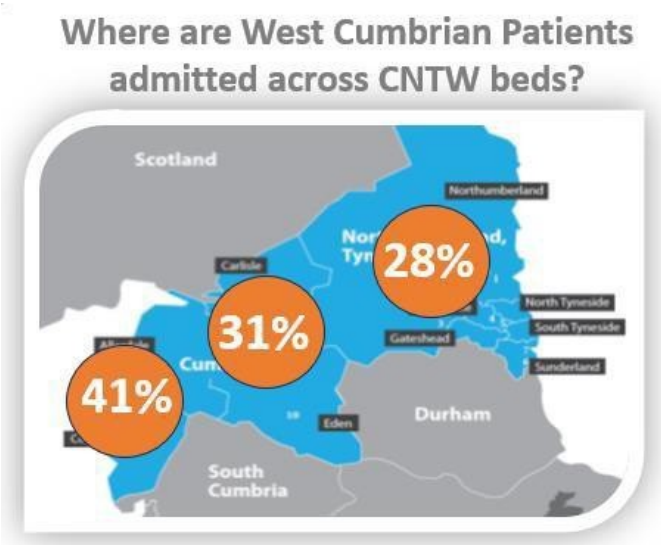
The majority of people using the Trust's secondary care mental health services in West Cumbria receive support from our community teams, including crisis services. At any given time, only 17 patients require inpatient care, while 4,100 individuals are supported in the community. Our dedicated staff have around 76,000 contacts with patients through community mental health services and 12,000 through crisis services a year, ensuring comprehensive care for those in need.



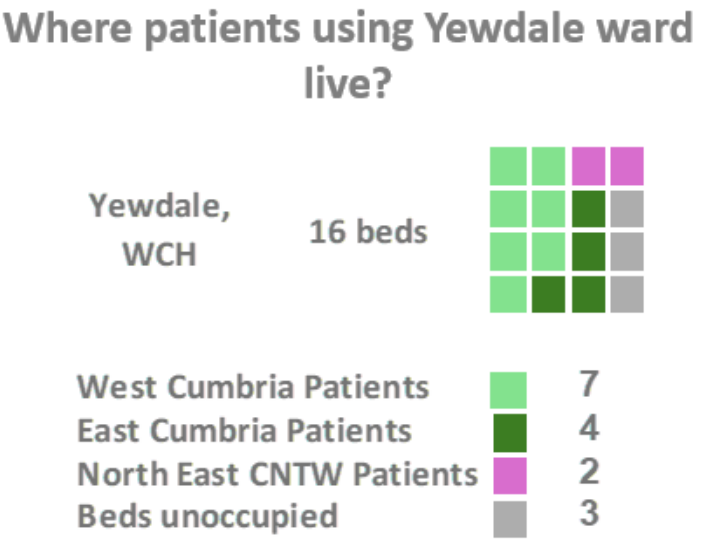
Source: CNTW RiO EPR



Source: CNTW RiO EPR



Source: CNTW RiO EPR



Source: CNTW RiO EPR

On a typical day, of the seventeen residents of West Cumbria who require in patient care, seven would be cared for in Yewdale Ward, five patients in the Carleton Clinic in Carlisle, and five patients in the North East, based on their clinical needs. Yewdale cannot manage the level of risk and complexity of a typical adult acute assessment and treatment ward due to its isolation. In addition, Yewdale Ward has operated with a restricted admission policy since June 2023 following a serious patient safety incident. These restrictions specifically include no admissions after 3pm during the weekday and no admissions on a weekend.

3. National policy drivers

3.1 National direction

The latest national guidance on **community transformation** in mental health is aligned with the new government's **neighbourhood health service models**. The NHS England National Planning guidance for 2025/26, published in February 2025 has a top priority for reducing demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and unnecessary admissions to hospital and improving timely access to care when it is needed urgently. The NHS England's Neighbourhood Health Guidelines for 2025/26 emphasise an integrated approach to health and care, building on existing structures like Primary Care Networks (PCNs) and other cross-team collaborations. The goal is to provide more care at home or closer to home, improve access, experience, and outcomes, and ensure the sustainability of health and social care delivery. The Copeland Area is a pilot site for the **24/7 neighbourhood mental health centres** which is one of the Neighbourhood Health Service Models.

The Trust has long been working to the national guidance on **community transformation** in mental health which emphasises a whole-person, whole-population approach, with the aim of developing integrated models of primary and community mental health care. This includes access to psychological therapies, improved physical health care, employment support, Housing and benefits support, personalised and trauma-informed care, and support for self-harm and coexisting substance use

The Trust has also been working to the Long-Term Plan national guidance **on mental health and urgent and crisis needs**, focusing on ensuring timely and appropriate care for individuals experiencing a mental health crisis. The NHS Long Term Plan emphasises the importance of providing comprehensive crisis pathways in every area, which can be accessed through communities, homes, emergency departments, inpatient services, or even ambulance transport and now 111 press Mental Health. The goal is to offer a range of crisis services, including crisis resolution home treatment, liaison mental health services, and alternative models like crisis cafes and safe havens. This approach aims to improve access, experience and outcomes for those in urgent need of mental health support.

The National Mental Health Inpatient Quality Transformation Programme and Commissioning Framework for Mental Services focus on local delivery of good quality mental health services for patients in their communities. To quote below:

"Localising care will require a phased implementation approach, which may include shortening stays, preventing inappropriate readmissions to inpatient services and ***redirecting resources from poor quality, and outdated inpatient provision towards the community****."* August 2024, Commissioning Framework for Mental Services

3.2 Regional (North East and North Cumbria) priorities

In July 2024, the North East and North Cumbria Integrated Care Board (ICB) produced their Mental Health, Learning Disability and Autism Inpatient Quality Transformation Plan in response to the national framework for inpatient quality transformation.

In September 2024, the improvement plan for mental health, learning disability and neurodevelopment was approved by the ICB. This plan identifies that bed occupancy and patients who are clinically ready for discharge but cannot be discharged due to housing and care capacity issues remains a challenge across the system.
However, the ICB confirmed that there is a consensus that additional assessment and treatment beds is not necessarily the right way forward. Instead, both commissioners and providers are focused on providing more effective early intervention and crisis / home treatment interventions, and strengthened discharge support.

The Integrated Care Board Mental Health, Learning Disability and Autism Inpatient Quality Transformation Plan has the following as top priorities for delivering change:

1. **Alternatives to admission across all pathways** - reduce reliance on inpatient services by enhancing crisis support and community-based alternatives.
2. **Improving complex care** - enhance case management and flexible support packages to prevent unnecessary hospital admissions and support individuals to stay well at home.

Working locally with partners and using lived experience experts, the Trust are implementing a **community services transformation programme**, embedding the following:

- Early access to joined up Mental Health and Wellbeing support
- No waiting
- Improved outcomes – people get better and stay well
- Management and support of people with severe and enduring mental illness
- Urgent and Crisis care support

3.3 CNTW model of care and support – with you in mind

In 2023, CNTW launched its strategy (link) for the future ***to work together, with compassion and care, to keep you well over the whole of your life.*** The strategy sets out five strategic ambitions to deliver the goals and changes we want to see across our services both now and in the future.

For community services we committed to take a radical approach in how we deliver community- based care which will:

- Consist of services and teams working together and rooted in our communities;
- Move away from a confusing system of referrals, assessments and treatment, to one of constant support and easy access to the right support at the right time;
- Ensure expert advice, support and skilled clinical help is available from our teams when they are needed;
- Make sure that there is support available for people all day, every day, within their communities, to meet their needs and enable them to keep well;
- Provide intensive wrap around support for people who need it most;
- Develop our services with our partners to address the areas of greatest need and health inequality;
- Develop real alternatives to inpatient care with our partners across our places so that where possible, we can support people in crisis within their own communities

For inpatient care we committed to:

- Protecting peoples human rights;
- Making sure our inpatient wards are welcoming and support healing;
- Ensuring staff have the right skills to support effective treatment;
- When people are ready to go home or need to move to a different ward, we will make sure this goes smoothly;
- Working with social care, housing providers, GPs and primary care so people stay well after their hospital stay;
- Designing services that avoid hospital stays.

During 2024, we have built on the commitments and ambitions set out in our strategy to develop our model of care and support, which will be rooted in the integration and collaboration with partners at a neighbourhood level to really understand the needs of people and support them to stay well. The future model of care and support is illustrated below.

Understanding you and helping you stay well

- Communities and organisations will collaborate more effectively to meet those needs and avoid multiple referrals between one another and work together to help people to stay well.

Community Treatment

- People will have quicker access to evidence-based treatments and interventions to meet their mental health needs.

Long term complex needs

- We will ensure assertive management for patients with complex and severe enduring mental illness and move away from episodic care for patients with long term needs.

Urgent and crisis care

- We will improve access to urgent care and work with our partners to support people with effective safety planning, identify deterioration quickly and provide access to crisis support and interventions.

Inpatient care

- We will ensure that patients admitted to inpatient care receive effective therapeutic care plans, and are supported to be discharged timely with the right support to ensure people stay well.

3.4 Hope Haven, Copeland, West Cumbria

In July 2024, CNTW was announced nationally as one of six 24/7 neighbourhood mental health centres to support the transformation in community mental health care.
The Hope Haven will be one of the flagship Neighbourhood Health Service models within Mental Health providing a focus on meeting the communities Mental Health and Wellbeing needs with a joined up person centred approach. By providing early intervention on the holistic needs of people it will prevent escalation to Mental Health illness and unnecessary admissions to hospital and improve the timely access to care and support. The Copeland Area is at the forefront of delivering the Model of Care and Support Model for our Trust. Work is developing at pace with the community, partners and people with lived experience on delivering this ambitious new approach. The main hub will be based in Whitehaven with a hub and spoke model to provide outreach into the wider communities across the Copeland area.

In line with the commitments we have set out, it was important to include the Hope Haven in the engagement exercise with the local population, given the critical importance this will have for the local community in improving wellbeing and providing better access to mental health care and support.

The measures of success for the Hope Haven are as follows:

- People's needs are understood and met more effectively
- Quicker access to wellbeing and mental health needs in the community
- Partners are delivering joined up and person centred care, with no wrong door
- Flexible transition between care pathways without cumbersome referrals and repeated assessments
- People's lives improve against a range of holistic wellbeing factors
- Fewer people experiencing mental health illness or progress to a mental health crisis, which consequently reduces the demand for secondary care services such as community support, crisis intervention, liaison within emergency departments, or inpatient treatment
- Improved staff wellbeing across all partners

- Longer-term outcomes for people across wider social determinants:
  - Reduction in suicide, anxiety and depression rates
  - Improved social factors such as reduced homelessness and unemployment,
  - Addressing wider health issues such as drug related deaths and obesity.
  - Strengthened community resilience and reduced isolation

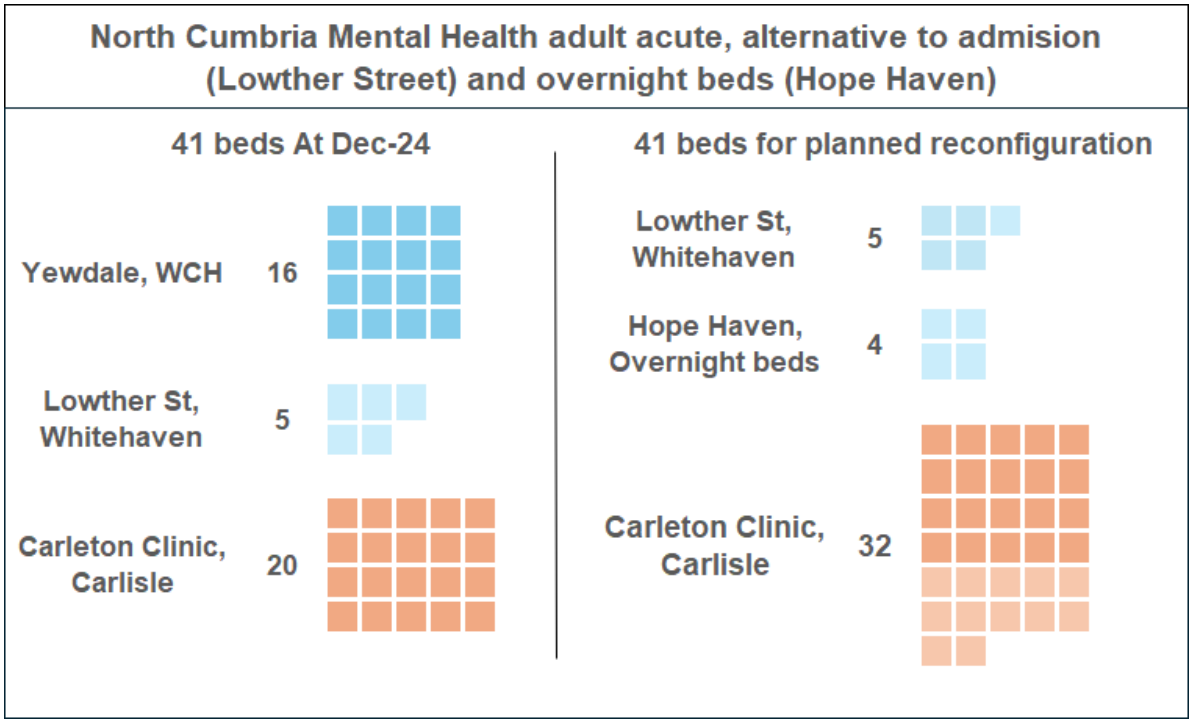
4. Rationale for re-provision of Yewdale Ward

4.1 Re-providing adult acute beds at the Carleton Clinic, Carlisle and Hope Haven, Whitehaven

Yewdale Ward is a 16-bed mixed-gender Adult Acute Assessment and Treatment ward is isolated on the West Cumberland District General Hospital in Whitehaven. In addition to Yewdale, North Cumbria has two other Adult Acute Assessment and Treatment wards, both based at the Carleton Clinic in Carlisle. This site also houses inpatient services for Older Adults and Learning Disabilities. Strategically it is important that across CNTW, inpatient services are located on hospital sites which have appropriate coadjacencies with other services which can provide back up support, infrastructure and open cultures.

Adult Acute Assessment and Treatment Inpatient wards are as follows:

- **Rowanwood**: 10-bedded Female Adult Acute ward, is expanding to 18 beds following refurbishment.
- **Hadrian**: 10-beded Male Adult Acute ward, is expanding to 14 beds following refurbishment.



The inpatient facilities at Hadrian (male acute ward) and Rowanwood (female acute ward) at the Carleton Clinic in Carlisle were outdated and required significant improvements to ensure safe, high-quality, and sustainable care. These wards have now been upgraded, and by March 2025, the number of available beds will increase from 20 to 32.

Yewdale Ward, with 16 beds, faces challenges, primarily due to its isolated location on a site without other mental health services. On average, only seven of these beds are occupied by patients from West Cumbria. To enhance mental health support in the area, four additional beds will be opening in Whitehaven as part of Hope Haven, providing permanent accommodation for individuals needing temporary mental health support with a different clinical offer. If Yewdale Ward were to close, 36 inpatient beds would still be available in North Cumbria, with 12 additional beds at the Carleton Clinic in Carlisle and four overnight beds at Hope Haven in Whitehaven, ensuring no reduction in overall capacity. There are also currently 5 beds that are alternatives to admission at Lowther Street, Whitehaven.

4.2 Yewdale Ward - challenges from a safety, quality, and patient experience perspective

Yewdale Ward sits approximately 40 miles away from the nearest main Mental Health hospital site at the Carleton Clinic Carlisle. In Whitehaven, the ward is located on the District General Hospital site for Physical Health care which creates challenges in delivering safe and quality care. During 2023/24 safety measures have been introduced to support the isolated nature of Yewdale ward with admission and case mix restrictions.

As described above, in 2024, the national inpatient quality programme was launched which sets out clear requirements for mental health inpatient services for the future. The programme has been co-produced with key stakeholders from across systems including service users, families, advocates, and clinicians, with the aim being to improve the quality and safety of care that service users experience within inpatient settings. This included moving away from isolated units, offering real alternatives to admission, and ensuring a clear therapeutic offer is in place when people need to come into hospital for their care.

Discussions with partners and the Integrated Care Board have taken place over the last 12 months to gain momentum for the longer-term direction of travel, particularly for isolated units, which includes Yewdale Ward.

The case for change in relation to the long-standing recruitment difficulties, isolation of Yewdale Ward and the risks of mixed sex accommodation required discussion and engagement with local partners and communities, which formally commenced in October 2024.

Included below is further detail and context in relation to the challenges and risks from a safety, quality, and patient experience perspective which have been included in the engagement discussions with staff and the local community.

4.3 Long standing challenges on Yewdale Ward including safety, quality, and patient experience

Isolation	The location of Yewdale Ward means it lacks the wider immediate support that a comparable ward on a main psychiatric hospital site would be able to draw upon. The primary concerns being the lack of an emergency response team, in the event of incidents on an adult acute assessment unit and the inherent risks of closed cultures developing in stand alone units.
Mixed Sex Ward	Yewdale ward is the only Adult Acute Assessment and Treatment inpatient ward in the Trust which provides care in a mixed sex facility. This is a concern in terms of sexual safety, privacy and dignity. In 2018 the CQC published a report on *Sexual Safety on Mental Health Wards* (CQC, 2018) and subsequently developments (e.g. The National Sexual Safety Collaborative commissioned by NHSE) emphasise the importance of improving sexual safety for patients, staff and visitors. Link to Care Quality Commission (CQC) report Sexual safety on mental health ward, 2018
Recruitment and Staff Retention	It provides a significant challenge for the long-term recruitment and retention of staff, particularly, from a consultant psychiatric provision which has been challenge that has not been able to be resolved over several years. The importance of ensuring the right skills and competencies are in place to provide therapeutic treatment and comprehensive admission pathways is essential to patient care and safety.
Medical cover and remote Responsible Clinician (RC) model	To comply with the requirements for detaining patients under the MHA, the Responsible Clinician (RC) role is provided solely on a remote basis due to ongoing difficulties in recruiting a permanent consultant psychiatrist. A recent CQC Mental Health Act reviewer visit raised concerns about the suitability of this fully remote RC model. Despite repeated efforts to recruit substantive doctors, vacancies remain, necessitating continued reliance on locum support. Currently, only one remote RC provides cover. Medical trainees were withdrawn from the ward due to insufficient consultation supervision, and below consultant level, the ward depends on staff grade medical staff. This is a quality and risk concern for patients and staff on the ward.
Deteriorating building	Yewdale Ward requires significant upgrade, a number of the issues are outstanding and require attention through the Service Level Agreement (SLA) with North Cumbria Integrated Care NHS FT (NCIC) estates service. Even with an upgrade this would not resolve the primary issues of it being an isolated, mixed sex ward.
Operational Delivery	In June 2023 to improve safety, changes to wards admission criteria were made, since then all admissions would be planned, and any new admission or transfer would take place prior to 15:00 hours on a weekday, with no admissions on a weekend. All potential admissions and transfers are screened by the Clinical team daily. This supports the team in managing the isolation issues. It is also a fundamental part of Enhanced Bed Management (EBM) bed allocation and does help support acute patient flow. Whilst this may provide short-term mitigations to some of the concerns highlighted above, it is limiting in terms of the effective use of a valuable acute inpatient resource.

5. Financial summary and value for money

The most recent NHS England planning guidance demands that Trusts reform, improve mental health services and improve value for money. This includes, modernising the service offer for patients, reducing unwarranted variation and taking tough local decisions when services need to change. The Trust's Model of Care and Support aligns with two of NHS England's key priorities: preventing ill health and reducing unnecessary hospital admissions. It emphasises providing joined-up, person-centred care and support within the community.

5.1 Current Income & Expenditure Position

The table below provides an overview of the current Income & Expenditure position for Yewdale ward. This indicates the service is currently operating with a £1.4m deficit from the £3m commissioned income, which is not financially sustainable.

Patient Care Income	**-3,034,185**
NPCI	0
Pay	1,955,631
Non-Pay	156,600
Group Support Costs - Clinical	912,522
Group Support Costs - Non-Clinical	300,050
Group Total	**3,324,803**
Non-Group Clinical Support	108,156
Corporate	426,468
Accommodation	695,998
Other Trust Costs*	-79,654
Service Support Costs	**1,150,969**
Surplus / Deficit	**1,441,587**

**Included in the figure above is a proportion of the £9m non-recurrent deficit support funding, which the trust received in 24/25, and was allocated across all services.*

5.2 Anticipated Savings

It is anticipated that there will be direct ward savings of £2.1m, primarily from ward staff costs, as well as a reduction in non-pay spend too, should the Yewdale service be re-provided elsewhere. Staff savings will be achieved, by the immediate reduction of any temporary staff costs directly associated with Yewdale. In addition, following appropriate staff consultation, substantive staff will be redeployed into vacant posts across other wards and services, therefore reducing the need for additional temporary staff use in other services too.

There is potential to release further staff savings from the clinical group support costs line, however, due to the increase in beds at Carleton Clinic, there will be additional support required to support the two wards based there. Further work will be undertaken as we continue to transition to the implementation of these beds opening and as part of the medium-term financial planning work.

5.3 Current Accommodation Contract with NCIC

In addition to the direct cost savings. Included within the accommodation line in the table above, there are costs associated with the contract held with NCIC, which will present further potential savings for CNTW.

There are on-going discussions with NCIC around the accommodation agreement for West Cumberland Hospital. The schedule below provides an overview of the current costs associated with J Block on the West Cumberland site, which is the current accommodation for Yewdale ward. The notice period for issuing notice to NCIC is 6 months.

NCIC Accommodation Contract – J Block (Yewdale) Costs

Occupied Floor Area	1,486 m2
Rent & Insurance	
Energy	**£52,769**
Water	**£7,499**
Rates	**£6,129**
Waste	**£7,451**
Domestics	**£99,247**
Portering	**£25,000**
Laundry / Linen	**£9,487**
Meal Provision	**£66,768**
Capital Charges & Interest	**£98,185**
Building Servicing	**£66,507**
Engineering Contract	**£48,727**
Total	**£487,769**

5.4 Financial Summary – Revenue

The Trust recently submitted its annual financial plan for 25/26 to the ICB, and this included the following planning assumptions, associated with Yewdale:

- £1.4m reduction across 25/26, phased in from July – (£2.1m recurring impact)
- £375k reduction across 25/26, phased in from July – (£500k recurring impact)

Should a decision be reached to re-provide the Yewdale beds elsewhere, then the savings identified in the section above would help the Trust achieve the 25/26 planning assumptions. This will ultimately help contribute to the in-patient care group's medium term financial strategy of delivering sustainable services for the future, and consequently help reduce the wider financial challenge across the Trust.

These savings are on the premise that there will be no retraction of income from the ICB, and current funding arrangements will be maintained to cover the costs of services.

6. Workforce analysis

On Yewdale Ward, there are 38 staff in total. The Trust has met with majority of the team (31) about the ward's potential closure and options to retain their skills and employment. Preferences for the staff who have engaged so far have been shared and are summarised as follows:

- Remain at West Cumberland Site (with NCICNHSFT): 8 staff (Initial engagement with NCIC underway to establish a memorandum of understanding).
- Remain in West Cumbria Locality (Community Care Group): 11 staff (Interested in community and access services).
- NCIC or Community (but cannot travel to Carleton Clinic): 4 staff.
- Deployment to Carleton Clinic: 3 staff.
- Relocation (North East or Carlisle): 4 staff (seeking information on opportunities).

Those that would like to be deployed to Carleton Clinic would require further exploration and professional discussions. This would support increased staffing pressures on the Carleton Clinic site with increased bed numbers across adult acute wards, greater reliance on Edenwood (learning disability ward) and existing pressures across older adults. Relocation opportunities could also include the Northeast and Carlisle which are being progressed with workforce colleagues.

Staff preferences for new roles are dependent on having a clearer understanding of the roles themselves and the skills required, to ensure we support people as far as possible into roles which utilises their skills and experience. Many of the staff team have worked in adult acute inpatient services for many years, staff emphasised the importance of robust job planning

and comprehensive induction programs to support their transition.

The Trust is continuing to work with staff to ensure they are updated and supported throughout this process. The Trust aims to avoid compulsory redundancies to ensure the retention of local skills within the Trust and to minimise any adverse economic and employment impacts within Whitehaven.

7. Engagement programme and overview

7.1 Summary of the engagement feedback

The Board approved an engagement programme in October 2024 to gather input from staff, service users, carers, and partners on mental health service challenges in West Cumbria. The programme aimed for open, two-way discussions about quality and safety concerns, as well as potential improvements. This strategic case for change will provide some of the highlights only from the full engagement outcome report that was shared with Trust Board in February 2025.

7.1.1 Staff Engagement

Starting in October, discussions were held with staff, including group and individual meetings, email updates, and a dedicated Teams channel. Key concerns included transport (both patient and staff impact), flexible working impact, skills fit, and relocation impacts.

7.1.2 Public and Partner Engagement

From 1 November 2024 to 17 January 2025, listening events took place in Whitehaven, Cockermouth, Workington, and Carlisle, with additional online sessions. Meetings were also held with councils, MPs, NHS bodies, and community organizations to ensure broad participation.

7.1.3 Key Themes the listening events, informal discussions, and meetings with stakeholders

- There was overarching support for improving community infrastructure.
- There was recognition of the challenges of social care crisis and community support.
- There was recognition that there are opportunities to join up services and make access easier and improve outcomes for people with mental illness.
- There were concerns about losing services from Whitehaven (and Cumbria).
- There were questions about how the new 24/7 hub in Whitehaven, Hope Haven, will work in practice, including the crisis beds.
- There were concerns about how people will be better supported to return to their

community following admission and continuity of care.

- People wanted assurance about the support that would be place for families and carers with travel when loved ones are admitted away from their home.
- The sessions provided an opportunity to enhance the public understanding of the recruitment challenges in West Cumbria.
- People wanted assurance that a key priority for the Trust will be to keep people in good jobs in the Whitehaven community.
- People wanted to understand the rationale for the proposal to re-provide Yewdale adult acute inpatient beds in West Cumbria to Carlisle now, rather than coinciding with the opening of Hope Haven.
- Clarity was required at an early stage about the decision-making process.
- Support for people in Crisis, particularly relating to suicide prevention and the recognition that a system-wide approach was needed.
- Ability to sustain long-term funding for Hope Haven.

7.1.4 Online Survey Analysis Summary

Survey responses were reviewed with a summary of key highlights below:

- **Environment:** West Cumbria services lack purpose-built facilities and are not integrated like Carlisle's. More clarity is needed on isolated unit risks.
- **Workforce:** Low morale, recruitment struggles, and concerns for relocated staff. More efforts needed to attract talent.
- **Crisis & Suicide Prevention:** High suicide rates demand stronger crisis services, early intervention, and better links with charities.
- **Carer & Family Support:** Families and carers need more support during admission and after discharge.
- **Wraparound Care:** Stronger multi-agency collaboration and better discharge planning are needed.
- **Service Access & Integration:** Services must be delivered by the right providers, with clearer admission criteria, stronger community links, and better coordination across health and emergency services.
- **Children & Young People:** More support is needed for youth mental health, including neurodiversity services.
- **Hope Haven:** Clearer communication on its role versus inpatient care and how it will support wider areas.
- **Other Issues:** Better public awareness of available services, rural isolation concerns, and ensuring patient/staff safety.

7.1.5 Social media comments/feedback

On 23 October 2024, the Trust commenced a programme of social media coverage to promote the West Cumbria Mental Health services engagement programme. This included:

Several comments were received in response to the promotions which focused on:

- Understanding the separation between Yewdale Ward and West Cumberland Hospital (the former being a CNTW service and the latter being an NCIC acute general service).
- Positive comments in terms of efforts to seek public opinion.
- Acknowledgement of the need to address the quality and safety issues.
- Removal of services from the West Cumbria locality in general.
- Positive comments regarding the compassion and care delivered by staff from people with lived experience.
- Concerns regarding accessibility for families and carers and treatment of people far from home.
- Queries regarding the work to date to address recruitment challenges.

7.1.6 Yewdale Ward patients engagement - People First

People First engaged with 11 patients on Yewdale Ward over the period of December 2024 to January 2025 and summarised the feedback about the ward, the possibility of it's closure and the opening of the Hope Haven.

In conclusion, most people who People First spoke to were happy with the care they receive, or had received, on Yewdale Ward. The feedback summary was as follows:

- The staff are generally regarded as caring, although there were some complaints of lack of privacy and a small number of staff appearing uncaring during admission.
- The activities that are on offer are good; however, patients would like a wider variety of activities including more fitness sessions and a gym.
- There were mixed comments on the facilities, however there is a general feeling that the ward could benefit from upgrading.
- There was an overwhelmingly negative response to the idea of Yewdale Ward facing closure in the future. Patients worry about where they will be sent to receive their care and are concerned about families being able to visit their loved ones.
- Those who chose to speak about Hope Haven generally did not think it would meet the needs of the local people due to the limitations of the low number of 72- hour beds.
- 3 of 4 patients were either not happy or said it was not ideal having a remote psychiatrist.

7.2 Trust response to the engagement

7.2.1 Summary of the positive responses from the engagement

- The Trust is showing a compassion for care
- The effort to focus on Quality and Safety for patients is welcomed
- The effort of the Trust to engage with the public is appreciated
- The Hope Haven is an exciting opportunity
- Yewdale ward needs an upgrade
- There is a lack of privacy on Yewdale ward
- There is a need to improve the quality of care provided
- Some patients are not happy with having a remote psychiatrist

7.2.2 Responding to the key concerns from the engagement

- *Patients don't want to lose a local service, and families would not be able to visit patients as easily*

Trust Response:

The Strategic Case shows that only seven Yewdale Ward patients are from West Cumbria at any time. Whitehaven already has five alternative beds, and Hope Haven will add four more for temporary accommodation. Since 60% of West Cumbria inpatients are already cared for in Carlisle or the North East, many won't see a change if Yewdale closes. Patients from other areas who have inpatient care provided on the Yewdale ward, and their families, will see a reduction in travel times and improved access.

Yewdale typically has 13 of its 16 beds occupied. Carleton Clinic in Carlisle will gain 12 newly refurbished beds, which will re-provide the adult acute assessment beds from Yewdale to Carlisle. In addition the four new beds at Hope Haven are a different offer and will support people with a temporary need, crisis support and alternative to inpatient admission under the Mental Health Act. Yewdale currently doesn't take the patients with a higher level of acuity of need due to its isolation, lack of response team and lack of a onsite consultant psychiatrist who fulfills the role of the Responsible Clinician. West Cumbrian patients would currently access this in Carlisle or the North East depending on the need.

Carleton Clinic has two separate wards for male and female patients. These wards are newly refurbished, located within a Mental Health hospital, and have onsite consultant psychiatric care, who work as part of a multidisciplinary team. Moving patients from Yewdale to these wards would eliminate the safety and quality concerns outlined in the Strategic Case, which cannot be fully mitigated against nor sustained.

Whilst there will be a local impact on local access to beds in Whitehaven, this is also important to look at in the context of the broader impact Yewdale ward has on acute bed capacity. The ward works with operational constraints now to admit people safely at weekends and out of hours (no admissions) which has a broader impact on local access for people across North Cumbria.

When past wards have closed, transport from the closed Ward to the alternative was provided for families to visit patients. Similar support will be put in place if Yewdale is closed. This is also applied across the Trust where patients have to travel now from their home locality where there are no specialist inpatient acute assessment beds.

- *Lack of clarity about what the Hope Haven will provide and if it will provide sufficient service to replace the ward.*

Trust Response:

Hope Haven is a multi agency collaborative service which supports the community by promoting mental wellbeing 24/7 and improving access to care and support. People will be able to access support for mental health experiences and help to identify what areas may trigger or drive their mental health distress.

Support is arranged across varied levels from providing advice and guidance to complex interventions. This includes community based 'Understanding You and helping you stay well'; 'Treatment Intervention - where needs are more complex and access to evidence based interventions may help the person's needs and 'Long Term Complex needs'- where a person may need longer term support and more complex interventions and oversight. Included in this approach is the acknowledgement that a person's needs may become urgent, and require tailored crisis support also a key part of Hope Haven's services. Some may need to access the 4 temporary accommodation for a short stay before being supported again in the community. This will enhance care for the people of Copeland but will provide an alternative not a replacement for an inpatient ward bed. This is in line with the national strategy to build real alternatives to inpatient admission and crisis support.

- *Will patients be supported properly when they return home?*

Trust Response:

When patients return home from an inpatient ward, they are currently supported by our Community Services and Crisis Team. This offer will remain in place to support people in their communities. The Hope Haven will improve this offer, developing how these teams at the Trust, other organisations and communities work closely together to provided person centred joined up community care.

- *Will the workforce be supported following the ward closure?*

Trust Response:

The workforce has been supported throughout this process, with individual concerns addressed. Staff are being helped to find new roles within the Trust and retain skills in the NHS in Cumbria. The Trust has been open and transparent in the long standing challenges facing Yewdale Ward, the changes which have been implemented operationally in how the ward functions and what this means for future sustainability.

7.3 Engagement with local MP and Overview and Scrutiny Committee

The Trust has presented the case for change and rationale to the Cumberland Overview and Scrutiny Committee and discussed key areas in relation to impact on local access, how these changes fit with the national policy direction and the improvements in outcomes which are required for the local population.

The trust has also engaged with the local Member of Parliament who specifically requested feedback on the following areas:

- *Detail how the new hub will be resourced beyond the two-year NHS England funded pilot.*

  As part of our model of care and support we will be making more shifts into community services from core resources which will form the basis of funding this service in the long term. The Trust does not see this as a pilot but a fundamental part of our model of care and support.

- *Provide further information on the services that will be offered at the hub and how it will be managed in a way that improves access to mental health services rather than simply sign posting people.*

  As outlined above in this strategic case and attached supporting presentation from partners on the hub. *Supporting enclosure 1.*

- *Explain why, when your data shows that on average 6-7 West Cumbrian patients reside on Yewdale Ward at any given time, the new hub only has four short-term beds. Can't you put in more?*

  As outlined above in the overall bed capacity for North Cumbria.

- *Pause your plan to close Yewdale Ward until your new model of care can be shown to have reduced demand for beds in the area below the level you'll be providing at the new hub.*

  Not a viable option given the quality concerns within the unit and the constraints these beds operate with now.

8. Governance and decision-making timeline

North East and North Cumbria Integrated Care Board colleagues have been supporting the engagement programme throughout the period, and have attended face to face events.

At the October Board member, a request was made around clarity of role and responsibilities for engagement, consultation and decision-making relating to service change.

It should be noted that there is no legal definition of service change but broadly it encompasses any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.

The high level timeline the Trust is working to is as follows:

19 February 2025	CNTW Board of Directors consideration of strategic case for change	For decision
21 February 2025	ICB MHLDA Sub Committee – presentation for information	For information
10 March 2025	ICB Executive Committee – consideration of strategic case for change and engagement process	For decision
30 April 2025	CNTW Board of Directors	For decision

8.1 NHS Providers/CNTW Board of Directors

NHS Trusts and Foundation Trusts, as Providers of services, are under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services. In regulation, involvement is also referred to as **engagement.**

Engagement helps to develop relationships with stakeholders including service users and staff, and organisations who have links to health and care. It provides an opportunity to share strategic ambitions, proposals for service change and the rationale for change, and more importantly, to seek the views of others to inform any proposals or future decisions. It is a two-way process which gives people an opportunity to contribute to decision-making and service delivery.

It is important that any Provider considering service change engages thoroughly, before requirement to move to any formal consultation is considered and to establish whether any further options to initial proposals have been or could be considered prior to decisions being made. It can also be known as pre-consultation engagement.

8.2 Commissioners/NENC integrated Care Board

Consultation is a formal process used in service change and has some statutory, and legal requirements. Whether formal consultation is required is determined by consideration of strategic business case, submitted by the Provider outlining the proposals for the service change.

The decision to enter a formal consultation stage is taken by the Commissioners (NENC ICB) and will involve discussion with NHS England. If formal consultation is required, this is undertaken by the Commissioners/NENC ICB (with support from the Provider organisation – CNTW). In making the decision to formally consult, commissioners/ NENC ICB will consider the following:

- Are services being completely withdrawn.
- Are services moving to another location which could cause 'considerable disruption' for service users.
- Will a particular cohort be unfairly disadvantaged by the proposals.
- Consideration of the engagement activity already undertaken by the Provider.
- The level of engagement with organisations including Healthwatch, Local Authority Overview and Scrutiny Committees already undertaken by the Provider.

9. Recommendation

The Board of Directors are asked to

a) Review and approve that the engagement process completed on the proposals has been robust with the local community and staff.

b) Agree the case for change proposal for the re-provision of services from Yewdale Ward to Carlile Clinic.

c) Agree that further consultation on the proposals is not required.

10. Supporting enclosures

None

Appendices

Appendix A – Quality Impact Assessment

Summary of service and/or pressures	Yewdale is a mixed gender inpatient service, providing psychiatric assessment and treatment in hospital whether under the Mental health act 1983 or voluntarily for adult patients. There are a number of issues highlighted in the trust's Engagement Plan which identifies the challenges and barriers to being able to provide effective care and treatment from Yewdale (including geographical isolation and incident response, recruitment and retention, sexual safety risks, and estate management). The trust believes that it is very unlikely that any further effort to enhance the inpatient offer on Yewdale ward will bring any value to patients and families in West Cumbria. Rather investment into making Carleton clinic a centre of excellence for service delivery, training and education as well investing into community alternatives such as Hope Haven will enhance the offer to the population of West Cumbria. **This QIA considers the impact of the potential closure of Yewdale.**

	Describe any potential quality impact that the scheme may have on each quality domain	**Describe any mitigations against negative impact that the scheme may have on each quality domain**	**Quality measures**
Patient safety	The patient safety concerns on Yewdale, and case mix restrictions put in place to mitigate risks, are a key feature of 'the case for change'. For patients who require admission, receiving care at Carlton Clinic would improve their safety due to a number of factors including, enhanced environment and a more robust MDT. Yewdale provides mix sex accommodation which increases the potential for sexual safety incidents. The unit is closed to admissions after 3pm on weekdays and take no admissions at weekends. A lack of a presence of a consultant psychiatrist on the ward impacts on treatment planning and patient safety.	The challenges and risks to patient safety experienced at Yewdale will be eradicated with the closure and re-provision to Carlton Clinic. Co-location of inpatient wards at Carlton Clinic allows for rapid site response and wrap around support in response to safety incidents. The introduction of 7 day working and EMDT, including a fully recruited medical team at Carlton Clinic will provide an enhanced offer for patients. Recruitment into senior medical roles has historically and currently proved to be much more successful at Carlton clinic site. This will be enhanced with the development of the new medical school in the area. Patients admitted to other acute wards have the benefit of receiving care on single sex facilities.	Compare and contrast level of patient safety incidents. Increased access to inpatient services with more appropriate and responsive admission times. Moving services from Yewdale to Carleton Clinic will not affect the duties and responsibilities of Safeguarding. It is expected the move will reduce the risk of incidents involving patients or staff and provide a better environment for patients and staff to support improved outcomes
Clinical effectiveness	MDT care is currently limited in effectiveness due to lack of inhouse consultant psychiatrists and resident doctors in substantive	Enhanced clinical offer at Carlton Clinic via the heart of the hospital concept.	Monitor patient and family/ carer feedback via Your Voice and through

	roles. This leads to limited opportunities for peer supervision and professional growth. Timely access to psychiatric interventions 24/7 which is not available at Yewdale ward due to the restrictions applied. Limitations associated with the Yewdale clinical environment having an adverse impact on care delivery.	A broader more robust MDT offering clinical input. Greater opportunities for peers / team supervision due to critical mass of mental health services and staff at Carlton Clinic which will have a positive impact on care delivery. Greater opportunities for pathway working. Greater alignment between the 136 facilities and the acute wards at Carlton Clinic. This will also have a positive impact on service user experience. National standards state that if people need to be admitted for hospital care then they should be looked after in modern, high-quality wards that provide single-sex accommodation The environment at Carlton Clinic, including outdoor space, state of the art technologies such as Oxevision, provides an enhanced care offer. More community alternatives to admission pathways with Hope Haven hub.	complaints and compliments Positive impact on LOS due to availability of a more robust MDT Culture of care initiative covers Carlton Clinic acute wards.
Service user experience	There is a recognition that for West Cumbria residents and their families, receiving inpatient care out of their natural communities may be problematic due to distance and limited public transport options. This has been identified in the People First Ward Engagement Report and the equality impact assessment. The transition of complex patients into community placements, potentially miles away from the ward, will need to be managed carefully. Current service user and carer experience is adversely affected by having no face to face meetings with senior medical staff.	The trust are proposing to address this concern via the provision of flexible transport options from Yewdale ward to Carlton Clinic. Work with Enhanced Bed Management Service to adopt a locality model to bed allocation therefore attempting to reduce moves from West to East and visa versa. Ensure West Cumbria inpatient have timely access / allocation to a community practitioner to support timely discharge and care within their natural community. Promote the use of the Hope Haven hub as a means of	Monitor patient and family/ carer feedback via Your Voice and through complaints and compliments Monitor utilisation of transport solutions. Capture activity levels of Hope Haven hub. Monitor West Cumbria resident usage of other trust inpatient facilities. Reduction in delays to admission for West Cumbria resident.

	No admissions after 3pm or at weekends to Yewdale necessitates admissions to other acute trust facilities regardless of clinical need. Yewdale accommodation does not support privacy and dignity due to it being mixed sex in nature.	mitigating potential inpatient stays and facilitating earlier discharge. In-house face to face assessment and treatment by psychiatrist and resident doctors at Carlton Clinic over a 7 day period will enhance service user experience and promote timely treatment initiation. Patients admitted to other acute wards have the benefit of receiving care on single sex facilities.	
Staff	Some staff have expressed concerns regarding the potential closure and re-provision of Yewdale due to issues linked to travel. There exists a cohort of staff within Yewdale who reside in the Whitehaven area, who continue to express negative views regarding the proposal irrespective of some of the expressed positive features. The MDT and Yewdale team have been adversely affected by the limited MDT membership. Peer group supervision is limited as a consequence of geographical isolation. Additional stressors on the staff by trying to effectively manage mixed sex provision. Resident doctors, medical staff and agency results in constant changeover. There is a risk of staff attrition near to the time of moving services to a new location	Individual 1-1 and group staff engagement sessions to discuss the future. Regular contacts with senior trust directors to discuss individual concerns. Discussions have commenced regarding internal and external employment opportunities (CNTW community staff, and NCIC). Individual transport requirement will be considered on a personal level during the staff consultation. Staff will be duly supported from a financial perspective as per their current terms and conditions of service. This will be mitigated by the establishment of strong staff communications as well as retention plans to ensure that any potential loss of staff is understood early and rectification plans put in place.	Staff retention Staff feedback via staff survey. Feedback during consultation.
Financial	It is anticipated that there will be direct staff cost savings of circa. £2,000,000 associated with potential re-provision of Yewdale services. There is a possible £500,000 saving associated with accommodation as part of the NCIC contract at West Cumbria.	The associated costs to support staff and service users and carers will be made available through the potential reductions in staff cost spend on the ward. From a staff perspective the methodology is set through their terms and conditions of service, however increased travel costs for	Financial delivery as per business case. There are high levels of satisfaction amongst staff in relation to the financial aspects of their redeployment.

	Linked to points raised above the Trust has committed to support families and carers with visiting arrangements costs, and also staff with re-location expenses too. The degree of this financial commitment is uncertain at the moment.	patients and or carers will be subject to further discussions.	Service users and families are satisfied with the travel arrangements arranged by the trust.
Political	Any potential reduction / re-provision of NHS services are anxiety provoking for the local population. This will result in greater levels of scrutiny from MPs, local councillors, staff side and other advocates. The ICB has a formal role to play if and when a decision is taken by the trust to support closure / re-provision of Yewdale ward.	There has been an open and frank dialogue between the trust and broad range of stakeholders both internal and external, including service users, carers and families. The development of the engagement plan has provided a framework for discussion with members of the public and their formal representatives at Health and Wellbeing Boards and other such forums.	Feedback from public – patients, families and advocates to measure the impact of move. Investment into community alternatives will continue to be monitored to provide anticipated benefits. The ultimate measure of quality and success is that we obtain support from key stakeholders to re-provide services from Yewdale to Carlton Clinic.

Approvals **Authors**	Group Nurse Director … Group Medical Director …… ……..

Approvals **Sign off**	Executive Nurse Director …….. Executive Medical Director ……..

Appendix B – Equality Impact Assessment

Equality Analysis			
Names of Individuals involved in Review	**Date of Initial Screening**	**Review Date**	**Service Area / Directorate**
Chris Rowlands	January 2025	As part of any decision process	Trust-wide implications
Proposal to be analysed		**Is this policy new or existing?**	
Mental Health Services – West Cumbria		New	

What are the intended outcomes of this work? Include outline of objectives and function aims

Yewdale Ward is an acute mental health inpatient unit based at West Cumberland Hospital in Whitehaven. It has 16 beds for adult men and women providing assessment and treatment by a multi-disciplinary team.

Yewdale Ward sits approximately 40 miles away from the main hospital site at the Carleton Clinic and is located in Whitehaven on the District General Hospital site (West Cumberland Hospital) and provides 16 mixed sex beds. During 2023/24 safety measures have been introduced to support the isolated nature of Yewdale ward with admission and case mix restrictions.

It provides a significant longitudinal challenge with staffing, particularly, from a consultant psychiatric provision which has been an issue for over 20 years. Its location also means it lacks the wider immediate support that a comparable ward on a main psychiatric hospital site would be able to draw upon and in the event of an incident or issue with staffing.

In 2024, the national inpatient quality programme was launched which sets out clear requirements for mental health inpatient services for the future. The programme has been co-produced with key stakeholders from across systems including service users, families, advocates, and clinicians, with the aim being to improve the quality and safety of care that service users experience within inpatient settings. The programme has five objectives:

- Localising and realigning inpatient services, harnessing the potential of people and communities.
- Improving the culture of care and supporting staff.
- Supporting systems and providers facing immediate challenges.
- Making oversight and support arrangements fit for the sector.
- Support least coercive care through reducing restrictive practices.

This includes moving away from isolated units, offering real alternatives to admission, and ensuring a clear therapeutic offer is in place when people need to come into hospital for their care. The Trust is working closely with partners on delays with discharge, which is important to reference given the broader challenges this poses across the Cumbria system, particularly for older people. CNTW recognises that improving community services, including crisis services is essential for West Cumbria and the new hub offers a real opportunity to realise the national ambitions for community and inpatient care. However, the Trust also recognises the engagement and open communication which is needed with the local community in relation to what this means for the future of Yewdale Ward, which is not sustainable.	
Who will be affected?	
Staff, Service Users and Carers	
Protected Characteristics under the Equality Act 2010.	
Disability	The census data shows – (with the caveat that we are almost at the midpoint of this census period) that around 20% of the population are disabled as defined under the Equality Act 2010. Consideration will need to be given to the accessibility of the transport infrastructure for disabled adults requiring inpatient services, where they do not have access to private transport.
Sex	Yewdale ward is the only Adult Assessment and Treatment facility in the Trust which provides care in a mixed sex facility, this is a concern from a sexual safety perspective. The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. In 2018 the CQC published a report on Sexual Safety on Mental Health Wards (CQC, 2018) and subsequently developments (e.g., The National Sexual Safety Collaborative commissioned by NHSE) emphasise the importance of improving sexual safety for patients, staff and visitors on mental health and learning disability inpatient pathways. Sexual safety is a priority area for CNTW as part of improving patient safety.
Race	Census data shows that circa 98% identify as white. Evidence from discussions with Public Health suggest this figure is now

	likely to be lower and therefore a more diverse population. Providing culturally competent services will be easier to achieve on our wards which are less reliant on agency staff. This links in with our focus working towards the Patient Carer Race Equality Framework – a mandatory requirement of the NHS Standard Contract for Mental Health Providers.
Age	From the census data (with caveats that may have changed as we reach the midpoint) 60.4% 16-64 years and a median age of 47. With this we need to look at other intersectional and socio-economic factors. 57% are economically active, however the census also shows that 21% have no qualifications – which may correlate with low income with possible links to health outcomes. Of the 57% who are economically active, 55% use a car to get to work. It is likely that those in greatest need may not have ready access to private transport to make the journey to alternative inpatient provision and equally may find the public transport that is available, is not readily accessible to them. The hub will ensure that people get the right care when they need it, which will reduce the need for inpatient beds. However, in situations where an inpatient stay is necessary, we may need to factor in the issue of transport to alternative facilities.
Gender reassignment (including transgender)	Yewdale ward is the only Adult Assessment and Treatment facility in the Trust which provides care in a mixed sex facility, this is a concern from a sexual safety perspective. The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. In 2018 the CQC published a report on Sexual Safety on Mental Health Wards (CQC, 2018) and subsequently developments (e.g., The National Sexual Safety Collaborative commissioned by NHSE) emphasise the importance of improving sexual safety for patients, staff and visitors on mental health and learning disability inpatient pathways. Sexual safety is a priority area for CNTW as part of improving patient safety.
Sexual orientation.	Yewdale ward is the only Adult Assessment and Treatment facility in the Trust which provides care in a mixed sex facility, this is a concern from a sexual safety perspective.

	The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. In 2018 the CQC published a report on Sexual Safety on Mental Health Wards (CQC, 2018) and subsequently developments (e.g., The National Sexual Safety Collaborative commissioned by NHSE) emphasise the importance of improving sexual safety for patients, staff and visitors on mental health and learning disability inpatient pathways. Sexual safety is a priority area for CNTW as part of improving patient safety.
Religion or belief	Intersectional issues around privacy and dignity for religion or belief arising from a mixed sex ward.
Marriage and Civil Partnership	Intersectional issues with sexual orientation and gender from a mixed sex ward environment.
Pregnancy and maternity	A mixed sex ward environment makes it difficult to address dignity and privacy issues for this protected characteristic at Yewdale. Being a single ward on an acute hospital site also raises the issue of how to ensure the health and safety of pregnant staff and the ability to provide cover for those that are on maternity leave.
Carers	The geographical isolation presents issues for carers, friends and family needing to travel to potential alternative inpatient provision at the Carleton Clinic, or other hospitals within the Trust. The provision of high-quality care within the new hub will do much to mitigate against this impact – providing the right care and the right time and place will lead to less admissions. Where treatment within an inpatient environment is necessary the net increase in beds on Hadrian Wards at the Carleton Clinic from 20 to 32 will help ensure that the hub plus Hadrian Wards will cover in loss of beds at Yewdale in the event of a decision to close being taken. In addition, the Trust has committed to support travel reimbursement or offer alternative transport arrangements for those affected by any potential future service change, which will help reduce but not remove the impact of any change.
Other issues to take into account	**Isolation**

	It is recognised and accepted that there are a number of limitations when trying to provide care from a geographically isolated site. The primary concerns being the lack of an emergency response team in the event of incidents on the ward, as well as limited senior management oversight. The recent publication of the *Independent Review of Greater Manchester Mental Health NHS Foundation Trust* (Shanley, 2024, paragraph 5.25) highlights the detrimental impact and missed opportunities that the lack of visible leadership can have on wards. To address these shortfalls, it has been necessary to deploy additional staff as a means of mitigating the concerns and stretching the available management resource to ensure appropriate levels of oversight at both Cumbria acute facilities – however, this approach is inefficient and not sustainable. Equally, the geographical isolation presents issues for patients, carers, friends and family needing to travel to potential alternative inpatient provision at the Carleton Clinic, or other hospitals within the Trust. The provision of high-quality care within the new hub will do much to mitigate against this impact – providing the right care and the right time and place will lead to less admissions. Where treatment within an inpatient environment is necessary the net increase in beds on Hadrian Wards at the Carleton Clinic from 20 to 32 will help ensure that the hub plus Hadrian Wards will cover in loss of beds at Yewdale in the event of a decision to close being taken. In addition, the Trust has committed to support travel reimbursement or offer alternative transport arrangements for those affected by any potential future service change, which will help reduce to impact of any change. **Backlog issues / deteriorating building** There are a number of environmental challenges on Yewdale Ward, and there are currently a number of outstanding estates issues, which still require urgent attention through the Service Level Agreement (SLA) with North Cumbria Integrated Care NHS FT (NCIC) estates service. These have continually proved to be a challenge in terms of priority for completion, and the standard of work undertaken. **Recruitment and Staff Retention** The location and distance from any major population centres makes the recruitment and retention of suitably qualified and trained individuals problematic. This has been a long-standing issue that is unlikely to improve over the medium to long term.

	Medical cover and remote Responsible Clinician (RC) model The most recent CQC Mental Health Act reviewer visit highlighted concerns around the suitability of a complete remote Responsible Clinician (RC) model. Despite numerous attempts to attract substantive doctors into the area, this has proved challenging and continually requires locum input. Currently there is only one remote RC to provide cover. The ward has no substantive junior doctor support, therefore relies on a locum junior doctor and SAS doctor. It also has Cumbria Health on call, relying on GP's attending for urgent physical health care needs, and Consultant on call cover during out of hours with no junior doctor cover. **Operational Delivery** In June 2023 to improve safety, changes to wards admission criteria were made, since then all admissions would be planned, and any new admission or transfer would take place prior to 15:00 hours on a weekday with no admissions taking place over a weekend. All potential admissions and transfers are screened by the Clinical team daily. This supports the team in managing the isolation issues. It is also a fundamental part of Enhanced Bed Management (EBM) bed allocation and does help support acute patient flow. Whilst this may provide short-term mitigations to some of the concerns highlighted above, it is limiting in terms of the effective use of a valuable inpatient resource.
How have you engaged stakeholders in gathering evidence or testing the evidence available?	
Through the public engagement programme phase	
How have you engaged stakeholders in testing the policy or programme proposals?	
Through a variety of methods including public engagement programme activity and the ability to provide written feedback.	
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:	
Public engagement programme Autumn 2024, the outcomes of each of these events has been documented and a summary report produced.	

Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.	
The mixed sex environment has a potential negative impact across 5 protected characteristics – when intersectional issues are taken into account. Provision of services in separate sex wards would mitigate this. Against this we need to balance and reach a solution (in the event of a decision to re-provide services from Yewdale to Carlisle) that addresses the geographical isolation of West Cumbria from our service users and carers' perspectives. It is clear from the evidence that service delivery will be improved in alternative inpatient facilities. What we need to ensure is that the Trust put in suitable measures to address the inaccessibility of the transport infrastructure for those that will need to travel to alternative inpatient facilities.	
Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic	
Eliminate discrimination, harassment and victimisation	Removal of mixed sex wards is likely to see the reduction in discrimination, harassment and victimisation.
Advance equality of opportunity	The hub will bring together a range of services and staff as one team, under one roof. People who are struggling with their mental health will be able to get specialist, intensive support from NHS services and other local organisations all based in the hub, this will lead to an advance in the equality of opportunity for people requiring Trust services in West Cumbria. This needs to be balanced against the potential need to travel to receive inpatient services.
Promote good relations between groups	There was a strong theme in the public engagement programme of the need to retain local services for local people. The development of the hub, especially when fully operational may help address the sense of loss from a potential service re-provision, but this must be weighed against the poor transport links, coupled with socio-economic

	factors that is likely to impact negatively in the event of a decision to re-provide services Yewdale.
What is the overall impact?	The development of the hub and net increase of inpatient beds on single sex wards at the Carleton Clinic is a positive impact, both in terms of equality, diversity and inclusion and the delivery of high-quality care. This must be balanced against the potential for negative impacts for travel to alternative facilities in the event of a reprovision of services from Yewdale to Carlisle for patients, carers, friends, family and staff.

From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010?

Yes – potential for negative impacts relating to geographical location of potential replacement inpatient services. It is recommended that this assessment is revisited to ensure in the event of a decision being taken to re-provide services from Yewdale to Carlisle, that suitable measures are in place to mitigate the risks of the impact as outlined above.

If yes, has a Full Impact Assessment been recommended? See above

Manager's signature: Chris Rowlands **Date:** January 2025

4. STRATEGIC AMBITION 3 - A GREAT PLACE TO WORK

Darren Best, Chair

4.1 PEOPLE COMMITTEE QUARTERLY ASSURANCE REPORT

Brendan Hill, Committee Chair

REFERENCES

Only PDFs are attached

4.1 People Committee Assurance report to Board - April 25.pdf

Report to the Board of Directors
30 April 2025

People Committee Quarterly Assurance Report
Quarter 4 report (January 2025 – April 2025)

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the People Committee. This includes an overview of the areas of focus, discussion and assurance and the Board Assurance Framework risks currently aligned to the Committee.

2. People Committee overview

The Committee

There has been one substantive meeting of the Committee during the period January 2025 – April 2025 (29 January 2025), and one development workshop (9 April 2025).

3. Board Assurance Framework risks within Committee remit

The People Committee is currently managing the following key risks on the BAF:

Risk No.	Risk descriptor	Risk score
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.	4 (likely) X 4 (significant) 16
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.	3 (possible) X 4 (significant) 12

4. People Committee focus January – April 2025

4.1 Assurance relating to risk 2542

This is predominantly received through the Workforce Performance Report which provides detailed information on areas including sickness absence, training, appraisal, recruitment and retention, and staffing including temporary staffing.

Compliance with five of the nine metrics for clinical staff priority training has been achieved. Compliance in the remaining areas continued to increase month-on-month. Following a discussion on the presentation of data, the Integrated Performance Report (IPR) will no longer include percentages to provide a more accurate reflection of the position.

Although appraisal rates have increased, these are not currently meeting the standard. A review of the Trust Appraisal Policy is underway. A proposal will be considered at the Executive Management Group to link the bespoke appraisal form in the Electronic Staff Record (ESR) to pay progression, the benefit of which will result in a positive impact on appraisal completion.

The Committee queried the increase in vacancies for medical recruitment across all Care Groups in relation to resignations. A deep dive is required in terms of the accuracy of data and any themes and future assurance on this will be provided to a future meeting. Currently the medical vacancy rate is around 8% compared to 22% regionally and 15% nationally.

In terms of wider recruitment, assurance was provided around NHS Employment Standards being met across non-medical and medical recruitment, including qualification checks. An annual internal audit on employment checks is also in place and is currently providing a 'Good' level of assurance.

A discussion took place regarding the high levels of agency use in the Cumbria locality, particularly in Crisis Services, linked to the number of vacancies. These longstanding issues have also impacted on community service agency use. A workforce plan linked to NHS111 urgent care in terms of triage capacity and home-based treatment around crisis is in place.

At the substantive meeting in January, the Committee noted an increase in sickness absence and noted regional discussions for all Providers to reduce sickness absence by 1%. At the April workshop, a focused development session was held on sickness absence looking at the national and regional picture, social determinants of sickness absence, and the work of the North East and North Cumbria Integrated Care Board sickness reduction delivery group. Lynne Shaw, Executive Director of Workforce and Organisational Development is the Senior Responsible Officer for the group.

Regionally, mental health continues to feature as the highest reason for absence. In-depth detail on the initiatives in place to support people back to work including specific initiatives from care groups was provided. Further assurance will be provided to future meetings around benchmarking and areas of good practice and learning from other organisations and detail on impact from local initiatives.

4.2 Assurance relating to risk 2544

A high level of assurance was provided through the Guardian of Safe Working Hours report which reflects the effectiveness of systems in place to measure, monitor, learn and support resident doctors working beyond their contractual hours. The Committee did recognise however the statutory responsibility to support doctors to ensure their ongoing wellbeing and the link around further work required as a Trust on organisational culture.

On review of the Employee Relations report ongoing work relating to the Respectful Resolution Tool Kit, the relaunch of the Give Respect, Get Respect pledge, and the forthcoming Sexual Safety Campaign was noted in response to some of the common themes identified. The launch of the Healthcare Support Worker Development Programme designed to foster team collaboration and positive culture was also welcomed. The work being undertaken by teams to reduce the number of cases was commended by the Committee but was recognised as an area of continuing improvement.

The Gender Pay Gap report for CNTW was received, and it was noted that it is highly likely that there will be a requirement under the NHS Standard Contract to report race and disability pay gap. The Committee welcomed this and will continue to review this as it develops.

The Committee received full assurance relating to the Better Health at Work Award 2024 submission. The Trust has maintained excellence in the award for eight consecutive years. In 2023, the Trust also received Ambassador Status on the recommendation of the Assessor.

The Committee reviewed the high-level results from the 2024 staff survey. Full results will be presented to the April Board of Directors meeting. Discussions around key themes and areas for

improvement will take place at the Trust Leadership Forum in the first instance to enable a focused approach to high priority areas and actions.

The Committee received the RIDDOR report (Reporting of Injuries, Diseases and Dangerous occurrences) which had a specific focus on violence and aggression assaults. This is also in the context of the Health and Safety Executive Notice received by the Trust in 2024. The Health Wellbeing and Attendance Policy has been reviewed with input from the Disability Staff Network and now incorporates a trauma informed approach. The importance of triangulating the work of the Violence Reduction Group and the Health and Wellbeing Group (a sub-group of People Committee) was noted in terms of strengthening assurance to the Committee.

At the April workshop, a development discussion took place on the health and growth accelerator and the regional wellbeing hub for health and care staff across the region. The Committee received detail on the three pillars of accelerator programme, person centred early intervention and prevention, supporting the health and care workforce and promoting good work and employer liaison. A detailed discussion took place on wider social determinants of health and ways to address major causes of health-related absence and economic inactivity in the workforce. The work of the regional wellbeing hub was commended and the need to consider longer-term sustainability of the hub was discussed.

4.3 Other issues and assurance received by the Committee

The Committee considered the annual review of the terms of reference prior to onward submission for Board approval.

A presentation was received at the January meeting from the Involvement Lead on how service user and carer views are influencing practice and the work of the Committee now and moving forward. This included how the workforce agenda utilises the experience of staff who are also services users, direct feedback from service user and carers, and use of the Involvement Bank. The Committee asked that further consideration be given to collating information into a single report to enable a clear picture of involvement across the Trust in terms of remit of the workforce and organisational development directorate.

5. Ongoing areas of focus for the Committee

Potential further workforce actions and priorities for the year ahead include:

- In the context of the development of the Trust workforce plan, improved mapping of current workforce and activity to better consistently budget across service type and localities.
- Develop and agree workforce/shift assumptions to enable better planning for future operational state including how existing and new job roles are utilised.
- Reduce waste and increase value adding work for our staff.

Other areas to further consider in terms of assurance are the impact of regional discussions and actions to reduce sickness absence, the increase in vacancies for medical recruitment across all Care Groups in relation to resignations, benchmarking and learning from best practice related to sickness absence and supporting people to return to work.

6. Summary and recommendation

The People Committee has continued to ensure alignment of the cycle of business with the Board Assurance Framework and ensuring the continued focus on assurance of the actions being taken to address key risks to achieving the Trusts Strategic Ambitions.

The Board is asked to note the content of the report and seek further assurance on any issues where appropriate.

Brendan Hill
Chair of People Committee
April 2025

4.2 STAFF SURVEY OUTCOME (INCLUDING ACTIONS/ AREAS OF FOCUS FOR 2025)

Lynne Shaw, Executive Director of Workforce and Organisational Development

REFERENCES

Only PDFs are attached

4.2 Staff Survey presentation 2024.pdf

2024 NHS Staff Survey

Summary of Results

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Lynne Shaw – Executive Director of Workforce and OD

With YOU in mind

National Headlines – Trends

Key Takeaways

50% response rate – up from 48% in 2023

No overall change in the nine theme scores from 2023

Positive: 2023 improvements were sustained, but no further progress in 2024

Most themes back to pre-COVID levels, with 7 at their highest ever:

- Compassionate leadership
- Health & safety climate
- Burnout
- Appraisals
- Support for work-life balance
- Flexible working
- Line management

Stable & Shifting Areas

Improvements in: Appraisal views, pay satisfaction, fewer staff considering leaving

Concerns:

- Violence & harassment from the public increased
- Discrimination from the public worsened
- Workforce equality gaps (WRES & WDES) remain unchanged

Workplace Engagement

- Willingness to recommend the NHS as a place to work and receive care remained stable
- Pay satisfaction improved slightly (from 31% to 32%)—driven by medical staff

CNTW Headlines

- Response rate of 42% - 1% increase on last year. The Picker average response rate for similar organisations* was 51%

- Mixed mode method applied with inpatient services receiving a paper copy of the survey and non-inpatient receiving the online version

- The survey opened on 30 September 2024 and closed on 29 November 2024

*Picker was commissioned by 21 Mental Health and Mental Health Community Trust organisations – results are in comparison to those organisations

CNTW Headlines (Former FFT Scores)

- ‘I would recommend my organisation as a place to work’, has decreased to 62% from 63% in 2023 and 65.1% in 2022

- ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation’ has decreased to 63% from 65% in 2023 and 2022

- ‘Care of patients/service users is my organisation’s top priority’ has decreased to 79% from 80% in 2023 and 83% in 2022

NHS People Promise

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.52	6.31	6.88	6.38	5.99	6.81	7.04	6.97	6.20
Best result	7.90	6.83	7.31	6.72	6.37	7.34	7.48	7.49	6.66
Average result	7.55	6.35	6.94	6.40	5.93	6.83	7.15	7.07	6.20
Worst result	7.03	5.98	6.18	5.86	5.11	6.27	6.78	6.32	5.46
Responses	3351	3346	3330	3328	3190	3333	3347	3349	3349

With YOU in mind

CNTW Results Summary

Areas of concern

The following areas have seen a decline from the 2023 results

- Staff feeling safe to speak up (68.8% in 2023 compared to 65.8% in 2024)
- Immediate manager values their work (77.6% in 2023 compared to 75.9% in 2024)
- Ability to make changes in own area and feeling involved in these changes that affect work
- Reduction in the section regarding ‘your team’ previously this had been an area we had done well in
  - ‘Team deals with disagreements constructively’ (61.8% in 2023 compared to 58.9% in 2024)
  - ‘Receive the respect I deserve from my colleagues at work’ (76.1% in 2023 compared to 73.7% in 2024)
  - Team has enough freedom to do its work (one of the bottom 5 scores)

CNTW Results Summary

Areas we have improved on

These results have seen an improvement against the 2023 results

- Above Picker average for staff unlikely to look for a new job at a new organisation within the next 12 months (Picker: 51.4% CNTW: 57.3%)
- Increased views that there are enough staff at the organisation (32.6% in 2023 compared to 34.6% in 2024) along with an improvement in staff working less unpaid overtime
- Above the Picker average for staff being able to access clinical supervision opportunities (79.6%) and increase in staff receiving appraisals (86.6% in 2023 compared to 90.2% in 2024)
- Increase in staff reporting harassment / bullying and abuse (69.2% in 2023 compared to 70.5% in 2024)

CNTW Results Top 5 scores

Top 5 scores vs Organisation Average	Org	Picker Ave
Last experience of physical violence reported	97%	90%
Last experience of harassment/bullying/abuse reported	71%	64%
I am unlikely to look for a job at a new organisation in the next 12 months	57%	51%
Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	48%	43%
Organisation acts on concerns raised by patients/service users	79%	74%

CNTW Results bottom 5 scores

Bottom 5 scores vs Organisation Average	Org	Picker Ave
Not experienced physical violence from patients/service users, their relatives or other members of the public	77%	85%
Team has enough freedom in how to do its work	56%	61%
Time often/always passes quickly when I am working	68%	73%
Staff involved in an error/near miss /incident treated fairly	54%	59%
Satisfied with extent organisation values my work	46%	51%

What is underway to support…

- Sexual Safety in the Workplace
  - Policy development
  - Training
  - Reporting

- Relaunch of the Give Respect Get Respect campaign
  - Bullying survey

- FTSU
  - Appointment of new guardians

- Developing a new violence and aggression risk assessment

- Launch of the new Leadership Development Programme

With YOU in mind

Work Ongoing

- ESR project - strengthen reporting on exit/leavers, flexible working, quality of appraisal and wellbeing conversations to enable ‘hot spots’ to identify additional support
- Continued communication to staff from previous Staff Survey results around the themes of the People Promise (feedback into action) including updates to the Staff Survey Results Dashboard
- Policy updates – links to becoming trauma informed and embedding ‘With You in Mind’ values
  - Resolution Policy
  - Health, Wellbeing and Attendance Policy
  - Appraisal Policy
- Trust Leadership Forum
- However, staff relate more to what is done locally and that is a key focus for groups and support services this year

Headlines from Bank Survey

101 bank staff responded

- 95% said they felt trusted to do their job
- 46% said they felt able to make improvements happen at work
- 58% agreed their immediate manager values their work, compared to 71% last year
- 70% are able to access learning and development opportunities when they need to (57.4% in 2023)
- Feeling safe to speak up regarding any concerns in the organisation 61.4% compared to 67% in 2023

4.3 EQUALITY, DIVERSITY AND INCLUSION BOARD OBJECTIVES 2025/26

Lynne Shaw, Executive Director of Workforce and OD

REFERENCES

Only PDFs are attached

4.3 Equality Diversity and Inclusion Board Objectives.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 4.3**
Date of meeting	Wednesday 30 April 2025		
Report title	Board Equality Diversity and Inclusion Objectives		
Report Lead	Lynne Shaw, Executive Director of Workforce and OD		
Prepared by	Lynne Shaw, Executive Director of Workforce and OD		
Purpose	**For decision**	**For assurance**	**For awareness**
	x		
Report previously considered by	N/A		
Executive summary	In June 2023, NHS England published the first NHS Equality, Diversity and Inclusion (EDI) Improvement Plan. This set out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. It was co-produced through engagement with staff networks and senior leaders. The plan centres around six high impact actions – the Board of Directors has previously been appraised of the content of the plan. This paper concentrates on High Impact Action 1 which requires Chief Executives, Chairs and Board members to have EDI objectives which are specific, measurable, relevant and timebound (SMART) and be assessed against these as part of their annual appraisal. Boards will be individually and collectively accountable for the objectives set. The objectives attached at Appendix 1 were co-produced with the Staff Networks. Board members will be set one or more of these when appraisals are carried out during the year and will be measured against them at their appraisal the following year.		
Detail of corporate/ strategic risks	Strategic Ambition 3 – Great Place to Work. Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up.		
Recommendation	The Trust Board of Directors is asked to approve the EDI Objectives outlined in the report for 2025/26.		
Supporting information / appendices	Appendix 1 – Board Objectives for approval.		

Appendix 1

INDIVIDUAL / JOINT BOARD EDI OBJECTIVES

	Objective / responsible officer(s)	How will this be achieved?	How will this be measured?
A	Increase awareness / understanding of Ableism and Internalised Ableism **RO: All Board Members**	Through training and / or workshop with the Disability Staff Network (DSN)	Greater understanding of challenges faced by disabled staff and service users, using this knowledge as part of Committee/Board decision-making Feedback from DSN
B	Increase awareness / understanding of Anti-Racism and Anti-Discrimination **RO: All Board Members)**	Through Board Development session and / or awareness training	Greater understanding of challenges faced by global majority staff and service users, using this knowledge as part of Committee/Board decision-making
C	Increase awareness / understanding of homophobia, biphobia, transphobia and other issues within affect the LGBTQ+ community **RO: All Board Members**	Through training/workshops with the LGBTQ+ Staff Network	Greater understanding of the challenges faced by LGBTQ+ staff and service users, using this knowledge as part of Committee/Board decision-making
D	Continue to support Network Meetings and wider Trust-wide EDI or Health Inequalities initiatives **RO: All Board Members**	Increased visibility at a range of network meetings and events (minimum 4 during the year)	Attendance/participation at events
E	Participate in the Trust's Inclusive Mentoring Programme **RO: a range of Board Members**	Mentor/mentee relationship with member of a staff network	Increased understanding of issues and challenges faced by staff Feedback from mentors as part of evaluation
F	To ensure that Board members have sufficient opportunities for development across EDI/Health Inequalities **RO: Chair**	Board Development Programme to cover any gaps in skills or knowledge identified	Board Development Programme participation
G	Oversee the delivery of the Patient Carer Race Equality Framework **RO: Chief Executive**	Through the development / implementation of the annual action plans which have been co-produced with communities	Improved relationships with communities Improvements in core data measurements
H	Lead the delivery/implementation of the Patient Carer Race Equality Framework **RO: Executive Director of Workforce and OD**	Through the development / implementation of the annual action plans which have been co-produced with communities	Improved relationships with communities Improvements in core data measurements

	Objective / responsible officer(s)	How will this be achieved?	How will this be measured?
I	Ensure that EDI/Health Inequalities is embedded in the work of (relevant) Committees, ensuring the voices of underrepresented people are heard and understood **RO: Committee Chairs**	Agenda and Papers to reflect EDI/Health Inequality priorities relevant to the (relevant) Committee	Review of Minutes Combined assurance reports through to Board
J	Continue to sponsor (relevant) Staff Network and support the co-chairs in the development of the Network and its objectives **RO: Executive Network Sponsors**	Attendance at Network Meetings Regular meetings with co-chairs Review of Network priorities to feed into the Trust-wide EDI action plan	Feedback from co-chairs as part of appraisal process Successful completion of Network specific objectives

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

Darren Best, Chair

5.1 RESOURCE AND BUSINESS ASSURANCE COMMITTEE QUARTERLY ASSURANCE REPORT

Brendan Hill, Interim Committee Chair

REFERENCES

Only PDFs are attached

5.1 RABAC Committee Assurance report to Board - April 25.pdf

Report to the Board of Directors
30 April 2025

Resource and Business Assurance Committee Quarterly Assurance Report
Quarter 4 report (January 2025 – April 2025)

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the Resource and Business Assurance Committee. This includes an overview of the areas of focus, discussion and assurance and the Board Assurance Framework risks currently aligned to the Committee.

2. Resource and Business Assurance Committee overview

The Committee receives assurance on the implementation and delivery of the following areas:

- Finance
  - (oversight of in-year financial performance (revenue), financial sustainability in the medium to longer-term, capital programme planning, and cash management).
- Estates
  - (oversight in ensuring our estate is fit for purpose, safe, utilised effectively and efficiently run).
- Digital
  - (oversight of the digital and technology agenda, assurance of regulatory compliance, ensuring internal systems of control are safe from a cyber perspective, oversight of the effective and efficient delivery of digital programmes, and ensuring we are a digitally enabled organisation for both our staff and our service users and carers).
- Sustainability
  - (oversight of the delivery of the Trusts Green Plan).
- Provider collaborative
  - (ensuring the Trust discharges its duties as lead provider adequately including contracting, financial sustainability).

There have been two meetings of the Committee during the period January 2025 – April 2025. Meetings were held on 31 January and 11 April.

3. Board Assurance Framework risks within Committee remit

The Committee is currently managing the following key risks on the BAF:

Risk No.	Risk descriptor	Risk score
Risk 2545	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.	4 (likely) X 4 (significant) 16
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.	3 (possible) X 4 (significant) 12
Risk 2547	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.	3 (possible) X 4 (significant) 12

4. Resource and Business Assurance Committee focus January – April 2025

4.1 Assurance relating to risk 2545

Assurance of the Trust financial position is predominantly received through the finance report which covers overall compliance with in-year control totals, staffing costs including use of agency, performance against capital programme and CDEL allocation, cash management and delivery of efficiencies.

Specific areas of focus have received more attention given the challenges relating to financial performance both in the short and medium term. This has included oversight of the development of our medium-term financial plan and sustainability for the longer-term. The focus during the period has been the increased emphasis on financial forward planning. As a key driver of costs within the Trust, this includes the shift from a previous focus on use of temporary staffing to looking at overall Whole Time Equivalent (WTE) usage as an organisation.

Discussions in the context of financial planning have included proposals relating to corporate efficiencies and service change including a detailed discussion on the Strategic Case for Change for adult acute inpatient services in West Cumbria prior to onward submission to the Board.

The Committee also has oversight of the Provider Collaborative with the Committee continuing to receive reports on quality, contracting and finance. The reporting of these issues now has an integrated approach to ensure oversight of the collaborative as a whole rather than individual aspects considered separately.

4.2 Assurance relating to risk 2546

In relation to estates and infrastructure, the Committee received updates on the CEDAR (CARE, Environment, Development and Re-provision) programme, Estates Return Information Collection reports (ERIC), Premises Assurance Model (PAM) reports. Annual updates on the sustainability agenda are received along with the minutes from the Sustainability, Waste and Transport Group for awareness/oversight.

The Committee recognised that the backlog position was challenging with estates and capital issues being reflected in Mental Health Reviewer visits during the period. The backlog position is under continual review with the intention of bringing forward additional support in the context of clinical impact. At present CDEL is still the regime the Trust are operating within and if spending continues on the new estate rather than maintaining existing estate, the Committee noted that their decisions may become more acute over the next 5 years and will need to be reflected in the medium term and sustainability plans for the Trust.

In relation to CEDAR, the Bamburgh unit at the St Nicholas Hospital site remains the only outstanding area of construction. The work to develop three ward blocks is well-established with a completion date of 23 June 2025 on track. Construction works are implemented in conjunction with the New Hospitals Programme with regular meetings taking place with key stakeholders. A moving date is on track for 18 August 2025 supporting the move from the Hadrian Clinic at the former General Hospital site.

4.3 Assurance relating to risk 2547

The Committee acknowledges the increasing emphasis on Digital to ensure digital is not a gap in assurance for the Board and development sessions have continued to help upskill the Committee to provide informed oversight of this agenda. This has included a focused session on the development of the Digital Strategy and how the Trust ambitions map to Digital Services and an

assurance report on digital services cyber assurance. The committee also considered the Digital Maturity Assessment in the context of Trust governance which will inform further developments in Digital governance. It is recognised that there remains a level of overlap/duplication across the Quality and Performance Committee and RABAC in this area.

The Committee received an update from Mary Lavender, Chair of the Disability Staff Network on the Digital Accessibility and Inclusion Project, increasing awareness of inbuilt accessibility features and Microsoft Copilot benefits. This was welcomed by the Committee in the context of the importance of the role of the Digital agenda in supporting the Trusts objectives around equality, diversity and inclusion.

The importance of health literacy and ensuring documents are accessible for service users, carers and staff was highlighted.

In April, a discussion took place on options to ensure stronger governance arrangements in respect to the Digital agenda including the establishment of a Digital Board Committee. A further update on this will be provided at a future meeting the next meeting, including a draft terms of reference for a proposed digital committee for review.

4.5 Other issues and assurance received by the Committee

The Committee also received key assurances on non BAF risk items as part of the regular system of assurance. These include updates and submissions associated with cost collection exercises, corporate benchmarking, and specific papers on planning and contracting which allow the committee to scrutinise the detail of Trust plans on behalf of the board.

5. Ongoing areas of focus for the Committee

Medium-term financial planning, delivery and sustainability will remain the key focus on the Committee during the next quarter. This will include review and oversight of service change proposals, corporate efficiencies and maximising resource allocation for inpatient services.

Clarification on Digital governance will also be a focus for the period.

The Committee continue to hold discussions within the context of the Trust strategic ambitions and supporting the delivery of the Model of Care and Support.

Summary and recommendation

The Resource and Business Assurance Committee has continued to ensure alignment of the cycle of business with the Board Assurance Framework and ensuring the continued focus on assurance of the actions being taken to address key risks to achieving the Trusts Strategic Ambitions.

The Board is asked to note the content of the report and seek further assurance on any issues where appropriate.

Brendan Hill
Interim Chair of Resource and Business Assurance Committee
April 2025

5.2 FINANCE QUARTERLY REPORT (QUARTER 4)

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

5.2 Month 12 Finance Report - April Board.pdf

Meeting	Board of Directors		Agenda item: 5.2
Date of meeting	30th April 2025		
Report title	Month 12 Finance Report		
Report Lead	Kevin Scollay, Executive Director of Finance		
Prepared by	Chris Cressey, Deputy Director of Finance & Business Development		
Purpose	For decision	For assurance	For awareness
		X	
Report previously considered by	The deadline for initial submission of Month 12 financial out-turn was 9 April. The Resources and Business Assurance Committee (RABAC) was verbally updated of the year end out-turn position at the meeting held 11 April. BDG-Finance received an update on 15 April and a full report will be provided to the Executive Management Group (EMG) meeting on 28 April. The deadline for the Trust's accounts and financial return for 2024/25 is 25 April.		
Executive summary	**Overall Financial Position** The Trust has met its financial plan for the year. The Trust end the financial year with and income and expenditure surplus of £4.238m**.** The Trust began the year with a planned deficit of £3.1m. This position is currently unaudited, which is normal at this point in the year. The Trust accounts are currently being prepared and the audit will commence imminently. The table below shows the movement in the Trust position to the reported year end position: **Planned Deficit** **(£3.1m)** Deficit Support Funding Q2 £1.4m **Revised Deficit** **(£1.8m)** CNTW improvement £0.3m ICB – Pressures Funding £5.2m NHS E – N/rec system support £0.5m **Forecast Surplus** **£4.2m** The Trust has received a significant value of pressures and system support funding which is non recurrent and therefore cannot be relied		

upon in the medium term and so the Trust needs to address this underlying deficit through its medium-term planning. A strategic risk is included in the Board Assurance Framework relating to this and is subject to regular review by RABAC.

Efficiency Delivery

The Trust has delivered its total efficiency requirement of £25.3m for 24/25. However, shortfalls on Inpatient and Corporate Department savings mean that recurrent delivery of savings is lower than planned by £7m. This means delivering financial balance in future years is becomes more difficult.

The Trust must also identify savings to cover the £8.4m non recurrent items already included in the efficiency programme for 24/25.

The Trust has an underlying financial gap moving into 2025/26 of £29m. This assumes full delivery of the recurrent efficiencies identified in the 2025/26 plan. The Trust has submitted a financial plan for 2025/26 for a £3.3m surplus. The 2025/26 plan includes circa £33m of non-recurrent benefits and efficiencies.

Capital Expenditure

The Executive Management Group received a review of the capital programme in October and agreed to a revised programme. The previous programme breached the allocated CDEL (Capital Department Expenditure Limit) by £2.4m. The revised programme was forecast to breach by £0.6m.

The Trust agreed with the North East and North Cumbria Integrated Care Board (NENC ICB) to re-phase the spend of some schemes to increase the spend in 2024/25 resulting in a breach of £1.6m reported in Month 11. This maximised the use of CDEL budgets for the Integrated Care System (ICS). The breach has increased to a £1.8m in Month 12 following the Northgate land sale slipping to 2025/26. The ICB are aware of the change.

The CDEL limits for 2025/26 have been issued and the NENC has seen a reduction in the core CDEL allocation. As the Trust delivered a surplus (net of deficit support) it is able to take advantage of capital incentive rules which apply in the 24/25 financial year. This means the Trust is able to increase its CDEL limit in 2025/26 by £2.9m, equivalent to the surplus delivered by the Trust (£4.2m surplus less £1.3m deficit funding). EMG has agreed to allocate £2m of the increase to the Older People's Service (OPS) scheme for 2025/26.

Cash Position

The Trust has a year-end cash balance of £43.5m. The Trust has been

	holding cash in deferred income for Provider Collaborative funding which has been agreed and funding is being released. The Trust has received deficit support funding from the ICB. The Trust has also received Public Dividend Capital (PDC) funding for Secure Data Environment (SDE) (£0.9m) and Sustainability (£0.7m) and made arrangements to draw down PDC for CEDAR (the Care Environment Development and Reprovision Programme) (£8.5m). The cash has been received and the payments are being processed. As a result, the Trust has a high cash balance at the end of the year.
Detail of corporate/ strategic risks	The two risks below are included on the risk register. Board Assurance Framework risk 2545 – Failure to deliver a sustainable financial position and longer-term financial plan will impact on the Trust's sustainability and ability to deliver high quality care. Board Assurance Framework risk 2546 – 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.
Recommendation	The Board is asked to: • Take assurance it has met its financial plan for the financial year, subject to audit, delivering a surplus of £4.2m. • Note the pressure on the availability of capital for 2025/26. The Trust has been able to submit a compliant capital plan for 2025/26 due to delivery of surplus in 24/25 – utilising capital incentive rules. • Note the Trust cash position, being aware the 2025/26 plan assumes a reduction in cash balances through the year to support delivery of the capital programme and maintaining the trust loan and PFI commitments.
Supporting information / appendices	None – detailed analysis is provided to RABAC as a standard information pack. This analysis is not repeated here.

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

Darren Best, Chair

6.1 INVOLVEMENT QUARTERLY REPORT

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

REFERENCES

Only PDFs are attached

6.1 Lived Experience Service Report 30 April 2025 (003).pdf

Meeting	**Board of Directors - Public**		**Agenda item: 6.1**
Date of meeting	Wednesday 30th April 2025		
Report title	Lived Experience Service Update		
Report Lead	Sarah Rushbrooke, Executive Director of Nursing, Therapies & Quality Assurance		
Prepared by	Alane Bould, Associate Director for Lived Experience		
Purpose	**For decision**	**For assurance**	**For awareness**
		x	
Report previously considered by	This report has been considered by the Quality and Performance Committee on 9th April 2025.		
Executive summary	The details provided in the Lived Experience Service report offers demonstrable evidence of continuing inclusivity through progressive and innovative working, however the report also identifies gaps and areas for further development. The Board are asked to note the report and the recommendations in 4 key areas: **Triangle of Care (ToC)** 1. Continue to hear about issues through inquiries and investigations, of carers who were not appropriately supported, listened to or included in the care of service users. 2. Ownership and regular oversight at a more senior level within the operational care groups. 3. ToC Sub-groups reporting to Quality Standards Groups should be in place in all operational care groups. 4. Action plans/Carer Awareness Training to be included as quarterly agenda items for monitoring performance at Quality Standards groups. 5. A ToC Dashboard system to enable performance analysis. 6. Carer Awareness Training is recommended for mandatory training. **Service User and Carer Reference Group (SUCRG)** 1. Utilisation of the SUCRG by operational care groups and corporate services and project leads to: inform/share good practice, evaluate and improve service delivery, involve the lived experience voice in co-creation from the outset of new projects, share national and local issues. **Meaningful Involvement at a Local Level** 1. In line with the views of the SUCRG and Trust Leadership Forum (TLF), structured networks to be put in place by care groups for lived experience engagement forums at a local level.		

	Peer Support Workforce 1. Consider recruitment of Peer Supporters where there are gaps in the peer support offer across operational care groups. There should be a robust peer support offer in Early Intervention Psychosis (EIP). 2. Operational care groups should consider a reallocation of the supervisor resource which would reflect the number of Peer Supporters in each of the care groups. 3. There should be a minimum of two Peer Supporters working together in an acute inpatient setting for their additional support against environmental triggers and 'burn-out'. 4. There should be support for a move from an acute inpatient setting to another service or care group where a Peer Supporter indicates that the environment is having a detrimental impact on their well-being.
Detail of corporate/ strategic risks	N/A
Recommendation	The report is provided for assurance
Supporting information / appendices	Appendix 1 – Lived experience service update

Appendix 1

Board of Directors
Wednesday 30 April 2025

Lived Experience Service Update

1. Executive Summary

The Lived Experience Service supports the coordination and facilitation of service user and carer involvement across the Trust, underpinning the ethos of the Trust's strategy 'With you in mind' as well as the 'Together Strategy'. There are two service domains known as the 'Involvement Service' and the 'Lived Experience Support Service'.

This paper is submitted to provide assurance of continuing and developing inclusive practice across the Trust, and to seek consideration on the recommendations made.

2. Quality Priority 3: Triangle of Care (ToC)

2.1 Triangle of Care Annual Report 2025

The Carers Trust offered a number recommendations under their 2024 accreditation review, for future annual reporting. The recommendations below were shared with operational care groups for their consideration in their annual assessment of performance against Triangle of Care principles.

a. Evidence of how carers are being involved (with consent) in discharge planning
b. Inclusion of year-on-year quantitative data, such as number of carers referred on to support
c. Examples of carer informed innovation to service change
d. Support for staff who combine work with a caring role – how the new right to unpaid carers leave is being implemented and benefiting staff
e. Adoption and implementation of the 'No Wrong Doors' for Young Carers
f. Plans to roll out the Patient and Carer Race Equality Framework

Care Groups are currently undertaking their annual self-assessments for year 2024-2025, with the deadline for the submission to the Involvement Service being 31st March 2025. The

Triangle of Care Annual Report 2025 will be submitted to BDG-Q for approval, before submission to the Carers Trust as evidence of the Trust's continuing commitment and application of Triangle of Care principles.

Key issues, significant risks, and mitigations
Operational care groups quarterly qualitative monitoring and reporting is not being demonstrated in a formal recorded process. Without a dedicated data collection and reporting system (Dashboard) the Trust is reliant on a workforce heavy manual process for the delivery of the annual review of performance against Triangle of Care principles.

Operational care groups have identified Quality Standards Groups as oversight for the reporting of progress in respect of service level action plans, identifying areas of concern for improvement and sharing areas of good practice for learning across services. Operational care groups have also identified that oversight will be underpinned by a Triangle of Care Sub-group of staff and carers, which will consider progress with action plans and could also consider issues coming from investigations and complaints.

Commissioning a Dashboard for Triangle of Care performance was identified by the Trust Leadership Forum to provide real-time comparative data for Quality Priority 3 reporting, as well as to provide services with the ability to analyse and report on their progress against standards. An application for a Triangle of Care Dashboard was submitted to the Strategic BI Group, in January 2025.

2.2 Creating a Carer Record Practice Guidance Note (PGN)
A project group of service users, carers, staff carers and clinical staff collaborated over several months to co-produce the new Creating a Carer Record – A guide for Staff Practice Guidance Note 11 (December 2024). An instructional video was provided in the Bulletin and made available on the intranet to inform staff of this critical change in the carer record management process.

The PGN now acts as an instructional document for staff in respect of the carer record. This inclusive project of service users, carers and staff has set the standard for lived experience collaboration in the future.

Key issues, significant risks, and mitigations
Risk of staff continuing to store carer information on a patient record.

2.3 Carer Awareness Training
Each operational care group must develop a training delivery plan to ensure that all staff receive carer awareness training on a 3-yearly basis to guarantee a long-term impact on staff practice. Planning includes the identification of appropriately experienced staff as Training Facilitators and all training sessions must be co-delivered with carer representation.

Carer-Awareness-Training---Delivering-the-Carer-Promise--Carer-Record-Update---6.1.25-

Each care group is responsible for ensuring that facilitators utilise the standard Carer Awareness Training Attendance Record (register) to record details of the training session and the attendees. Operational care groups must forward a copy of attendance registers to: cntwacademy@cntw.nhs.uk, to be entered on staff records.

Carer awareness training plans are not readily apparent in operational care groups nor the monitoring of staff attendance at delivered training sessions. Academy reporting on carer awareness training shows a Trust wide record of 1,333 staff having attended the required training over the past 3-year period.

Key issues, significant risks, and mitigations

Risk of staff not being made aware of essential information based on the four pledges within the Carer Promise. Failings in respect of inclusive carer practices continue to be raised as areas for improvement in investigations.

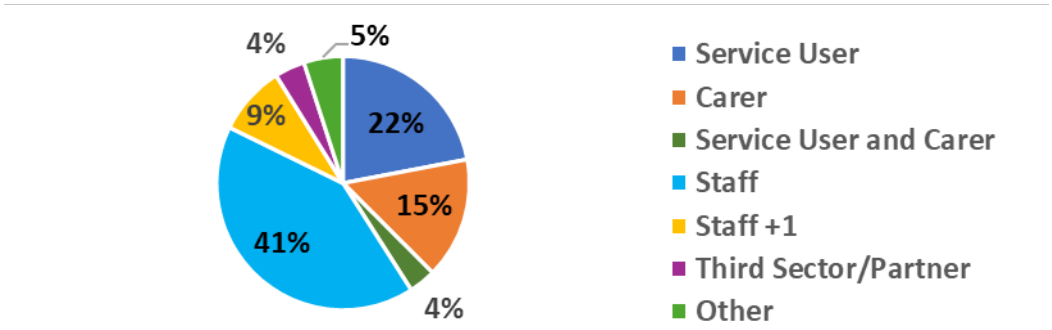
Completion of carer awareness training has been identified as a concern in a number of Triangle of Care annual reports. Consideration of carer awareness training as a mandatory requirement was also identified by the Trust Leadership Forum, and this has been taken forward for discussion by the Academy.

3. Lived Experience Engagement

3.1 Service User and Carer Reference Group

The Service User and Carer Reference Group Trust-wide is a lived experience led engagement platform. It continues to be well attended with increased numbers requiring a change of venue to St James Park, Newcastle, which will accommodate further growth. Attendance figures, where people choose to share information on classification, demonstrates service user and carer attendance at 59% of attendees. However, it is accepted that a number of staff in attendance may also be a service user or carer.

Average Attendance Chart (2024)



Two new Co-Chairs and a Deputy Chair were appointed in February 2025, they will bring fresh perspectives to the content and delivery of the Service User and Carer Reference Group going forward. Margaret Adams will continue to provide valuable support to the group and the new appointees as a Co-Chair.

Margaret Adams
Co-Chair

George Moat
Co-Chair

Heather Lee
Co-Chair

Fatema Rahman
Deputy Chair

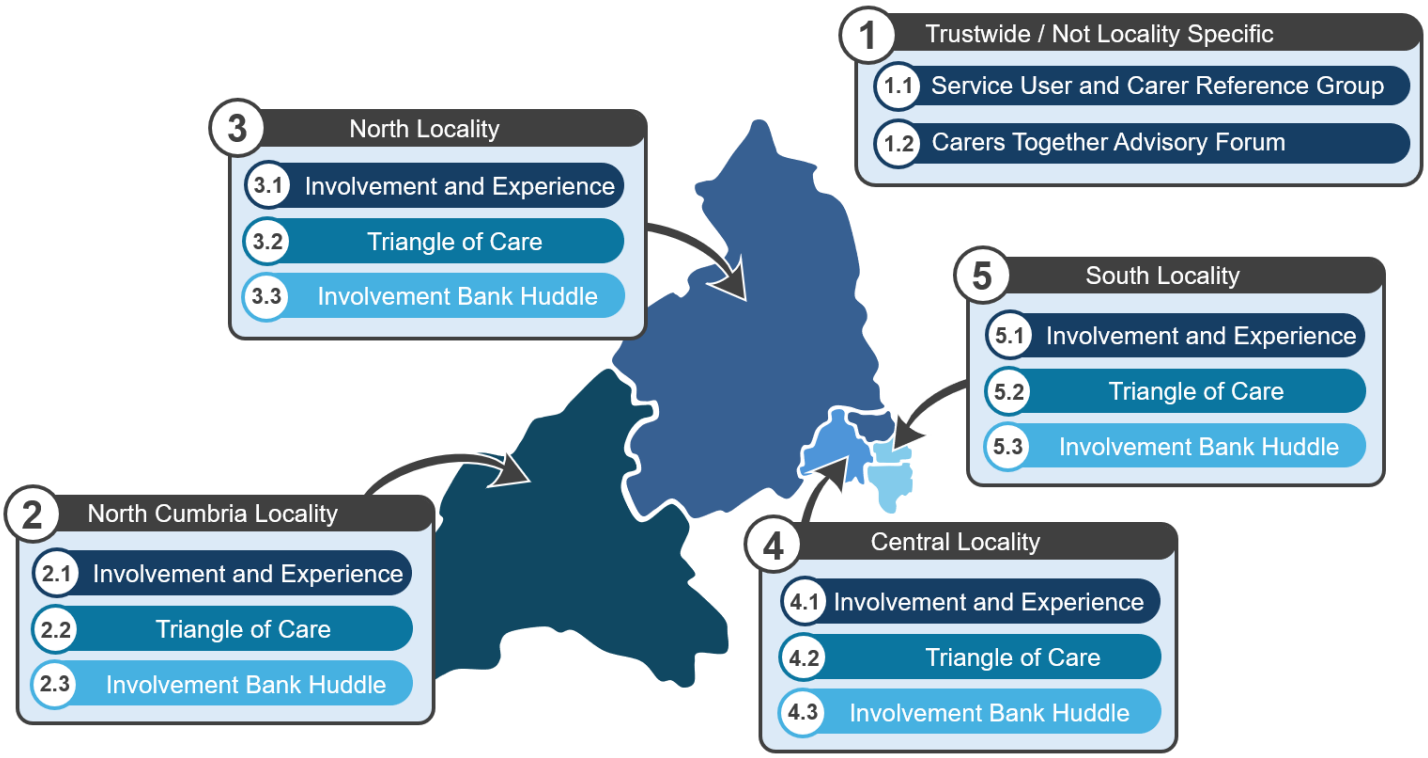
Key issues, significant risks, and mitigations
Continuing risk of staff attendees out-weighing service users, carers and partner organisations. It is essential that the Reference Group remains a service user and carer engagement platform therefore a staggered approach to invitations is used, with service users and carers provided with the Eventbrite notification first, followed by partner organisations and then Trust staff.

3.2 Lived Experience Forums

To ensure that the lived experience voice is represented at an operational level, a survey to ascertain the current landscape of service, ward or team forums was undertaken. The outcome of the survey provides details of forums hosted by operational care groups, with a summary of the forum's focus.

Additionally, there are a number of forums and groups facilitated at a Trust or local level that do not sit with a specific operational care group.

Trustwide Forums



Service User and Carer Reference Group
A Trust-wide forum that meets bi-monthly. Each meeting has a different focus, with teams and services sharing key Trust projects and initiatives with the group for reference, comment and discussion.

Carers Together Advisory Group
A carer specific advisory group, meeting quarterly and reporting directly to Business Delivery Group – Quality (BDG-Q).

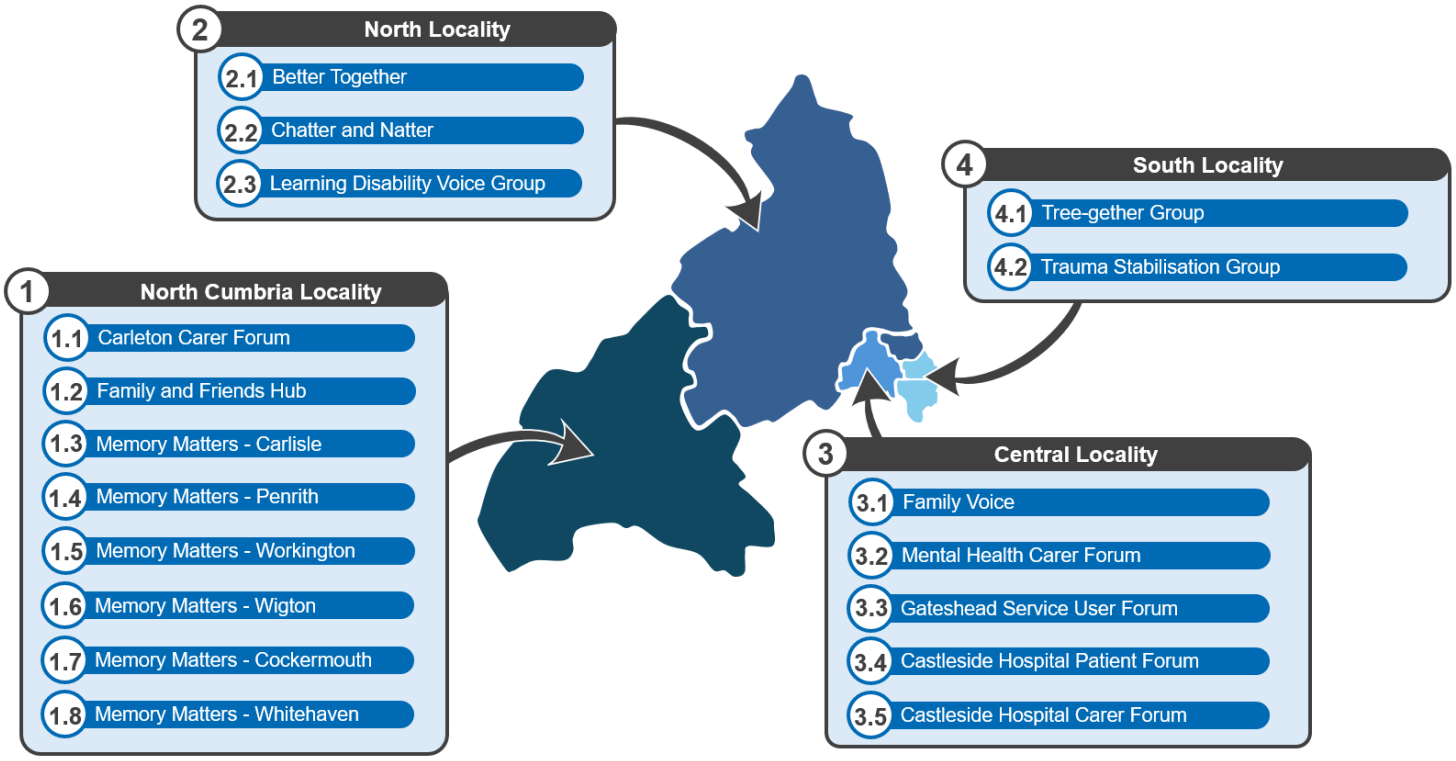
Involvement and Experience Groups
Locality based groups with a membership of service users, carers, staff and third sector organisations.

Triangle of Care Groups
Focussed groups where carers support staff, acting as a critical friend, to evidence work undertaken under the six key principles of the Triangle of Care.

Involvement Bank Huddles
A safe space where service users and carers registered on the Involvement Bank come together to share good practice, offered support and developmental opportunities.

Community Care Group

The following list shows an overview of all known service user and carer forums in operation within the Community Care Group. Groups marked with ** indicate that the offer is for both inpatient and community service users and carers, and as such are listed in more than one care group.



1.1 Carleton Carer Form**

The group is a casual, informal gathering for carers and family members of people who receive inpatient and community mental health support.

1.2 Family and Friends Hub**

The hub offers carers and family members not only wellbeing support and educational sessions, but also an opportunity to help shape services.

1.3 – 1.8 Memory Matters

The group is a casual, informal gathering for carers and family members of people who receive care from Older Adult services. Carers come together to support each other and shape services.

2.1 Better Together

This group is designed for autistic adults and their families and friends, providing a platform to have their voices heard, form friendships and gain support.

2.2 Chatter and Natter**

This gathering is intended for carers, providing a supportive environment where they can meet and connect offering an opportunity for sharing advice and guidance.

2.3 Learning Disability Voice Group

Service users and carers from Learning Disability Services share experiences and meet new people.

3.1 Family Voice**

A forum for family members of someone accessing memory services (community or inpatient).

3.2 Mental Health Carer Forum**

The group is for carers and family members of people who receive inpatient and community mental health support.

3.3 Gateshead Service User and Carer Forum

Gateshead Community Treatment Team working together with service users to learn and improve services.

3.4 Castleside Day Hospital Patient Forum

A forum for patients accessing Castleside Day Hospital.

3.5 Castleside Day Hospital Carer Forum

A forum for carers accessing Castleside Day Hospital.

4.1 Tree-gether Group

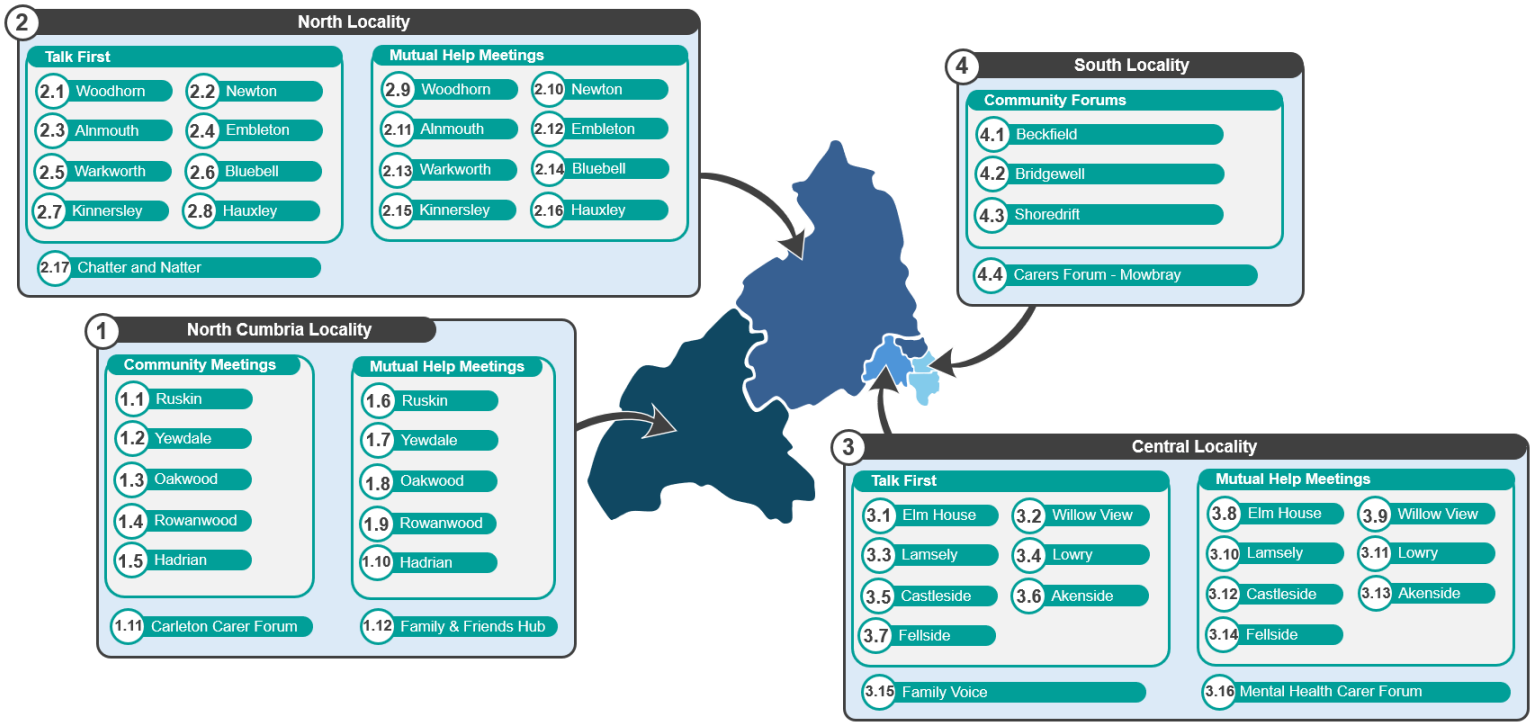
A group for adults with a learning disability, autistic people and carers who work together with staff from Sunderland Community Learning Disability team.

4.2 Trauma Stabilisation Group

A Community Trauma Stabilisation Group that is open to service users and carers who currently access South Tyneside Community Treatment Team.

Inpatients Care Group

The following list shows an overview of all known service user and carer forums in operation within the Inpatient Care Group. Groups marked with ** indicate that the offer is for both inpatient and community service users and carers, and as such are listed in more than one care group.



1.1 – 1.5 Community Meetings (North Cumbria)

Community meetings occur regularly on the ward. These meetings bring a sense of community to the inpatient setting; giving an opportunity for service users, staff and families to engage with each other.

1.6 – 1.10 Mutual Help Meetings (North Cumbria)

These meetings allow patients to discuss how they can support one another and express their needs for assistance from fellow patients.

1.11 Carleton Carer Forum**

The group is a casual, informal gathering for carers and family members of people who receive inpatient and community mental health support.

1.12 Family & Friends Hub**

The hub offers carers and family members not only wellbeing support and educational sessions, but also an opportunity to help shape services.

2.1 - 2.8 Talk 1st (North)

The Talk 1st programme aims to focus clinical team's resources and expertise on avoiding the use of restrictive interventions. Led by the ward manager, these monthly meetings

provide patients currently staying in hospital with an opportunity to voice and discuss any concerns they may have.

2.9 - 2.16 Mutual Help Meetings (North)
These meetings allow patients to discuss how they can support one another and express their needs for assistance from fellow patients.

2.17 Chatter and Natter**
This gathering is intended for carers, providing a supportive environment where they can meet and connect offering an opportunity for sharing advice and guidance.

3.1 – 3.7 Talk 1st (Central)
The Talk 1st programme aims to focus clinical team's resources and expertise on avoiding the use of restrictive interventions by promoting compassion driven care and removing conflict and flash points. This is done through making patient voice central to everything.

3.8 – 3.14 Mutual Help Meetings (Central)
These meetings allow patients to discuss how they can support one another and express their needs for assistance from fellow patients.

3.15 Family Voice**
Forum for family members of someone accessing memory services (community or inpatient).

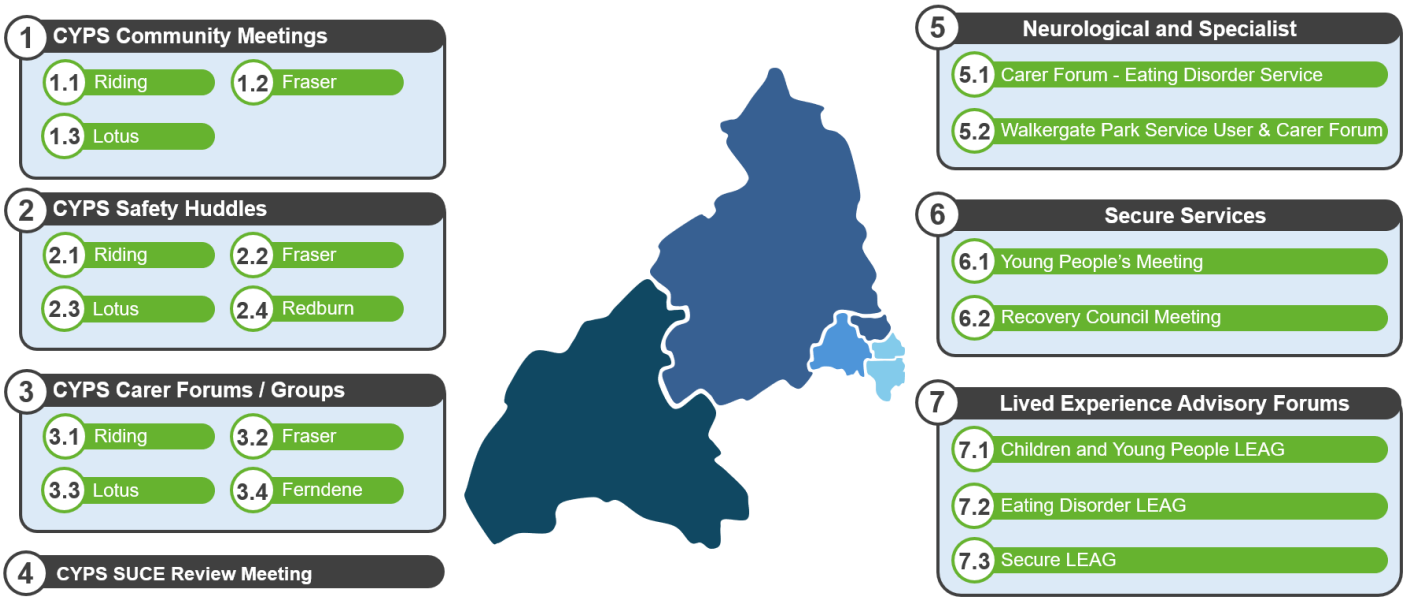
3.16 Mental Health Carer Forum**
The group is for carers and family members of people who receive inpatient and community mental health support.

4.1 – 4.3 Community Forums (South)
Community forums, otherwise known as mutual help meetings, are a voluntary meeting of all patients and the staff on duty, which enable patients to provide feedback about their care and treatment.

4.4 Carers Forum (Mowbray)
The group is a casual, informal gathering for carers and family members of people who receive mental health support to share experience.

Specialist Services Care Group

The following list shows an overview of all known service user and carer forums in operation within the Specialist Services Care Group.



1.1 – 1.3 CYPS Community Meetings

Community Meetings, otherwise known as Mutual Help Meetings, are a voluntary meeting of all patients and the staff on duty, which enable patients to provide feedback about their care and treatment.

2.1 – 2.4 CYPS Safety Huddles

Daily Safety Huddles where young people and staff have an opportunity to discuss how safe the ward environment feels, and any changes that need to be made to ensure this.

3.1 – 3.4 CYPS Carer Forums / Groups

A forum for family members of someone accessing Children and Young people services.

4. CYPS SUCE (Service User Carer Experience) Review Meeting

A meeting for service users, carers and services to come together to discuss service user and carer involvement and experience, influencing change within CNTW.

5.1 Carer Forum – Eating Disorder Service

A forum for carers of people accessing Eating Disorder Services.

5.2 Walkergate Park Service User and Carer Forum

A forum for patients accessing Walkergate Park. This forum is currently undertaking a review.

6.1 Young People's Meeting
Young People's meeting to discuss service provision in secure setting.

6.2 Recovery Council Meeting
Nominated patient representatives to discuss issues, projects, and what's going well within the wards. Representative takes minutes and shares with peers within ward community meetings.

7.1 – 7.3 Lived Experience Advisory Forums
The Lived Experience Advisory Group (LEAG) is co-chaired and attended by experts of mental health services in their capacity as a user of services or a carer, and service providers bringing two different perspectives of access, delivery, and receipt of services.

Key issues, significant risks, and mitigations
Significant amount of uncertainty from staff on whether there was a service user and/or carer forum provision in their service or the definition of a forum. Locality Involvement and Experience Group meetings have previously highlighted that forums are not well promoted in operational areas.

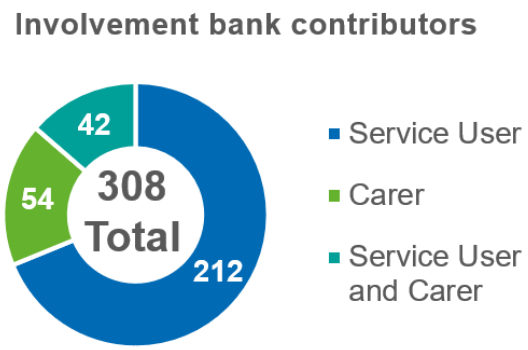
Engagement at a local level has yet been aligned to the restructured operational care groups. Group Nurse Directors are considering the formation of lived experience engagement platforms at local level.

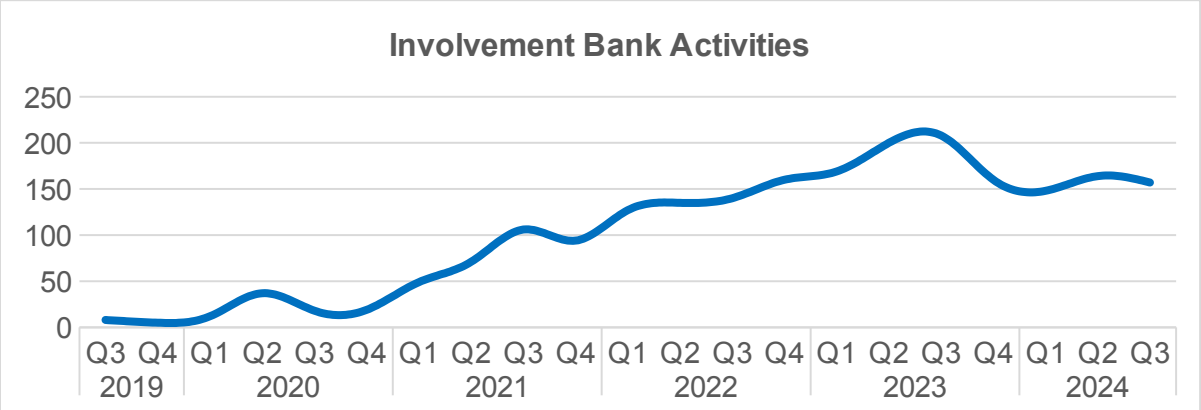
4. Involvement

4.1 Involvement Bank

Involvement Bank membership continues to grow, with 308 Contributors currently active, representing a broad range of lived experience.

The Involvement Service continues to provide support to Involvement Contributors with 1:1 support in activities as and when required, and an offer of development and support at monthly meetings in each locality. Staff throughout the Trust continue to submit Involvement Activity requests across all themes categories.





Key issues, significant risks, and mitigations
Whilst we can finally see a potential levelling of activity requests, the continuing increase in members active on the Involvement Bank obviously means that there will be a reduction in allocated activities for contributors.

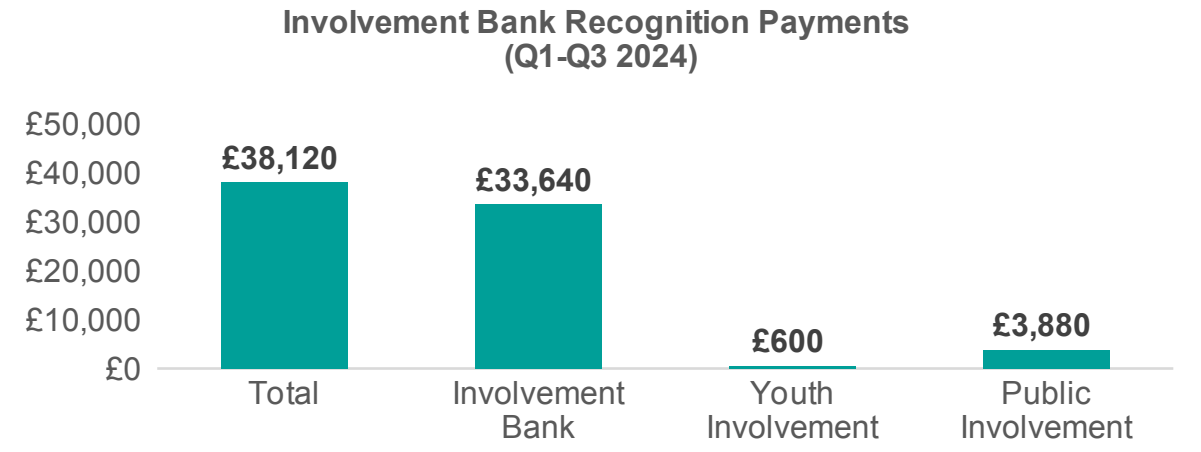
In order to ensure that activity requests have been allocated fairly and in line with established processes, the Involvement Service is undertaking an audit against allocation criteria/procedures. The audit will cover the period of Quarter 3 allocations from October to December 2024.

4.3 Youth Involvement Bank

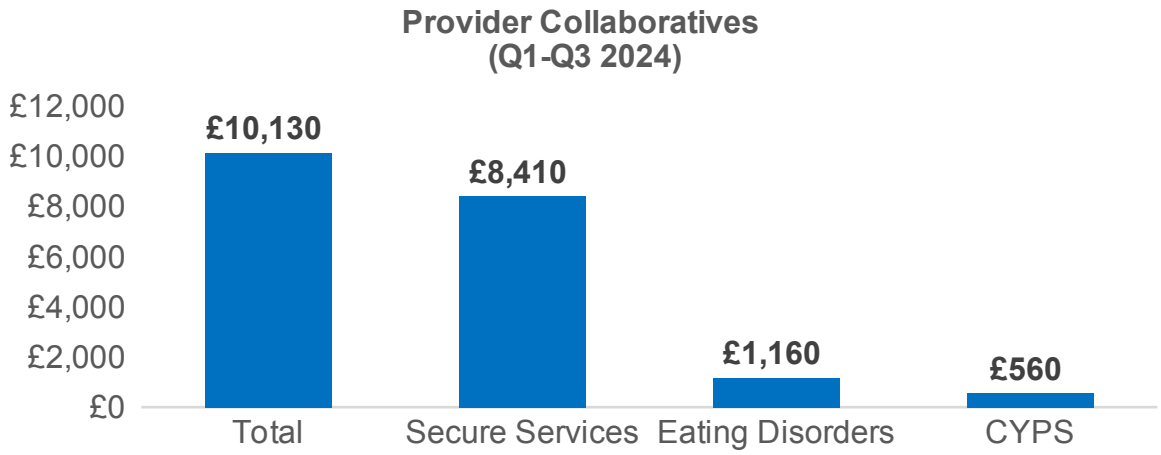
The Youth Involvement Bank provides young individuals aged 14-17 with opportunities to engage in involvement activities, using their lived experiences to influence the design and delivery of services. The aligned Involvement Facilitator for the Youth Involvement Bank held a session with CYPS staff to emphasise the significance of listening to the voices of lived experience and how the Youth Involvement Bank can support collaboration.

4.4 Recognition Payments

The recognition payment (Recognition Payments Policy - CNTW(O)85) is a discretionary sum that the Trust offers to service users and carers who undertake involvement activities in respect of the Trust, the Provider Collaborative, and external partners where appropriate. It is in acknowledgement of giving their time and contribution, payments are made through the Trust's Cashiers Department on a monthly basis.



Provider Collaboratives recognition payments are currently administered on behalf of the Eating Disorders, Secure Care and CYPS collaboratives.



Key issues, significant risks, and mitigations
An annual audit of compliance against the Recognition Payments Policy - CNTW(O)85 is carried out internally by the Involvement Service which involves a review of the annual report of payments that have been processed by the Cashiers Department. Audits have provided assurance of significant compliance with the policy.

Disparity between collaborative payments has been highlighted to and considered by Secure Services.

4.5 Public Involvement (Non-Bank) Activity

The Involvement Service supports involvement activity outside of the Involvement Bank process (also known as public involvement), offering operational and corporate services the ability to work collaboratively with service users and carers who choose not to become a member of the Involvement Bank. Support includes the administration of recognition payments when the activity is registered with the service. Where activity is registered this provides the Trust with further demonstrative evidence of inclusivity and co-production.

Non-Involvement Bank Activity Q1-Q3 2024

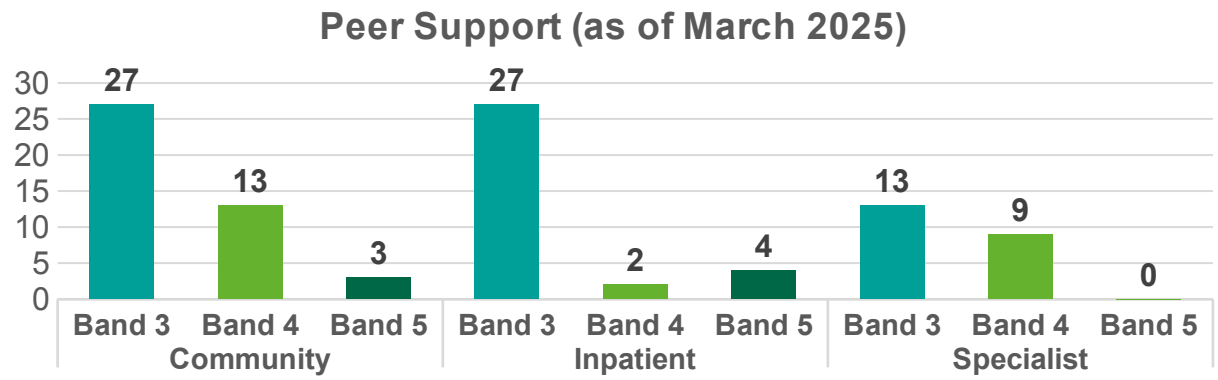
Key issues, significant risks, and mitigations
Where activities are not registered with the Involvement Service, there is potential for demonstrable evidence of involvement to be overlooked in records and reporting.

5. Lived Experience Workforce

5.1 Peer Support in Operational Care Groups

There are 98 Peer Supporters in post (March 2025 Workforce figure), which is a reduction from the year end 2024-2025 figure of 104. Turnover has generally been due to moves outside of peer support for career development opportunities or retirement. The Lived Experience Support Service has however supported several peer support recruitments over the past 6 months (some with successful candidates who are not yet in post), including areas that are new to peer support, such as Complex Neuro-developmental Service (CNDS), Attention Deficit Hyperactivity Disorder (ADHD) Services and Hope Haven (Community Hub) in West Cumbria.

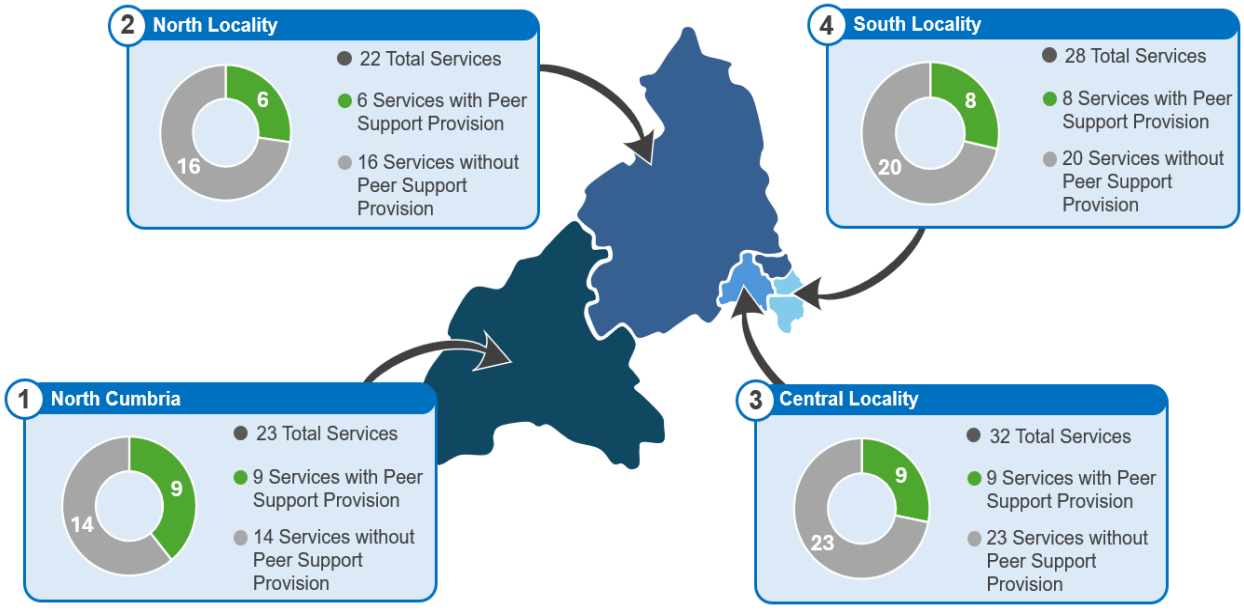
The operational restructure has resulted in disparity of Peer Support Supervisor (PSS) resource across the care groups which is causing difficulties in support and development provisions.



Peer Support Provision across Care Groups

Charts below show services with peer support provision of one or more Peer Supporter, and services which as of March 2025 Workforce reporting, do not have a Peer Supporter in post. The underpinning service specific information provides the related working time equivalent.

Community Care Group provision



Community Care Group – North Cumbria

Peer Support Provision

- Perinatal Community Mental Health Team — Peer Support: WTE 1.0
- Children's LD and Behaviour Support (East) — Senior Peer Support: WTE 0.6
- Children's LD and Behaviour Support (West) — Peer Support: WTE 0.6
- Memory Matters and Later Life Service (East) — Peer Support: WTE 1.0
- Crisis Resolution & Home Treatment Team (East) — Senior Peer Support: WTE 1.6
- Crisis Resolution & Home Treatment Team (West) — Senior Peer Support: WTE 0.6
- ADHD Children and Young People's Service — Senior Peer Support: WTE 0.6; Peer Support: WTE 0.6
- Early Intervention In Psychosis Service — Senior Peer Support: WTE 1.0
- East Community Treatment Team — Peer Support: WTE 1.2

No Peer Support Provision

- Child & Adolescent Mental Health Service (East)
- Child & Adolescent Mental Health Service (West)
- Community Autism Assessment Service
- Community Eating Disorder Services
- Cumbria At-Risk Mental State (ARMS) Service
- Memory Matters and Later Life Service (West)
- NHS North Cumbria Talking Therapies
- Learning Disability Community Nursing Team
- North Cumbria Psychiatric Liaison Team North
- North Cumbria Psychiatric Liaison Team West
- West Community Treatment Team
- Primary Care Mental Health Team
- Section 136 Suites
- Street Triage Cumbria

Community Care Group – North Locality

Peer Support Provision

- Children & Young People's Intensive CTS — Peer Support: WTE 1.0
- Crisis Resolution and Home Treatment Team — Peer Support: WTE 1.0
- Central Northumberland Adult CTT — Peer Support: WTE 0.5
- Children and Young People's Service — Peer Support: WTE 1.0
- EIP Northumberland — Peer Support: WTE 0.6
- North Northumberland Adult Community Treatment Team — Peer Support: WTE 0.6

No Peer Support Provision

- Initial Response Team Northumberland
- Psychiatric Liaison Team
- Older People's Intensive Response Team
- Older People's Psychiatric Liaison Team
- Community Treatment Team North Tyneside
- EIP Team North Tyneside
- North Northumberland Older Adult Team
- At-Risk Mental State Service
- Northumberland Behaviour Support Team
- Northumberland Memory Service
- Primary Care Mental Health Team – North Tyneside
- Primary Care Mental Health Team – Northumberland
- South Central Northumberland Older Adult Team
- South Northumberland Adult Community Treatment Team
- West Northumberland Adult Community Treatment Team
- West Northumberland Older Adult Team

Community Care Group – Central Locality

Peer Support Provision

Crisis Resolution and Home Treatment Team **Senior Peer Support: WTE 1.0**	Newcastle Psychiatric Liaison Team **Senior Peer Support: WTE 1.0**	Adult ADHD Service **Senior Peer Support: WTE 1.0**	Children and Young People's Service **Peer Support: WTE 1.0**
Gateshead East CTT **Peer Support: WTE 1.0**	Gateshead West CTT **Senior Peer Support: WTE 1.0**	North and East Newcastle CTT **Peer Support: WTE 2.0**	Newcastle West CTT **Senior Peer Support: WTE 1.0** **Peer Support: WTE 1.0**
Newcastle and Gateshead Step Up Hub **Senior Peer Support: WTE 1.0**			

No Peer Support Provision

Children and Young People's Intensive CTS	Gateshead Adult Psychiatric Liaison Team	Hadrian Clinic Physical Treatment Centre	Hopewood Park Physical Treatment Team
Older Adults Crisis Resolution and Home Treatment Team	St George's Park Physical Treatment Centre	Street Triage North of Tyne	Street Triage South of Tyne
Adult Autism Diagnostic Services	Castleside Day Hospital Dementia Support Service	Central At-Risk Mental State Service	LD including Positive Behavioural Support
EIP Service Newcastle	EIP Team Gateshead	Gateshead and Newcastle Homeless Service	Gateshead Community Team Learning Disability
Individual Placement Support Employment Service	Memory Assessment Service Newcastle	Newcastle Behaviour Support Service	Younger People with Dementia Service
Newcastle North Older Peoples CTT	Newcastle East Older Peoples CTT	Newcastle West Older Peoples CTT	

Community Care Group – South Locality

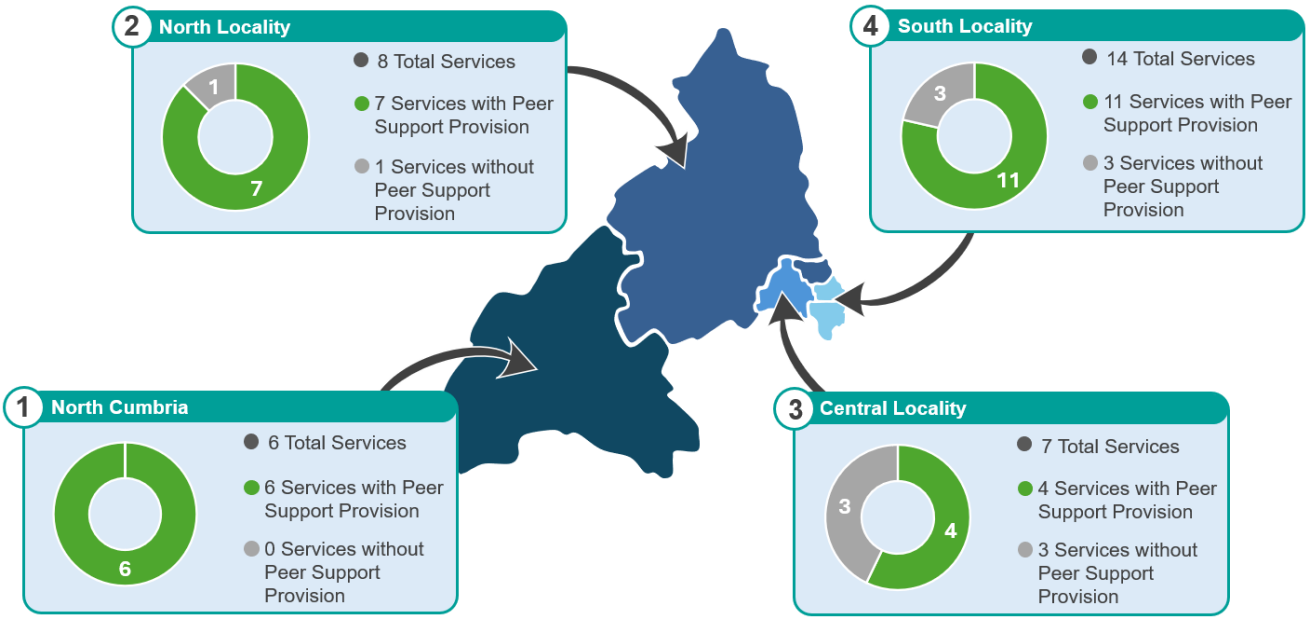
Peer Support Provision

Psychiatric Liaison Team Sunderland **Peer Support: WTE 0.6**	EIP Sunderland and South Tyneside **Senior Peer Support: WTE 1.0** **Peer Support: WTE 2.0**	South Tyneside CTT (Non-Psychosis) **Peer Support: WTE 1.0**	South Tyneside CTT (Psychosis) **Peer Support: WTE 1.0**
South Tyneside Step Up Hub **Peer Support: WTE 0.8**	Sunderland North CTT **Peer Support: WTE 3.0**	Sunderland South CTT **Peer Support: WTE 1.0**	Sunderland West CTT **Peer Support: WTE 1.0**

No Peer Support Provision

111 IRS Team	Children & Young People's Intensive CTS	Crisis Resolution and Home Treatment (Sunderland)	Crisis Resolution and Home Treatment (South Tyneside)
Initial Response Service South of Tyne	Veterans Mental Health and Wellbeing service	Psychiatric Liaison Team South Tyneside	At-Risk Mental State (ARMS) Service
CYPS South Tyneside and Sunderland	Gateshead and South Tyneside LD Psychological	Memory Protection Service Sunderland	NHS Sunderland Talking Therapies
Primary Care Mental Health Team – South Tyneside	Primary Care Mental Health Team – Sunderland	South Tyneside Primary Care Physical Health Service	South Tyneside Older Adult CTT
Sunderland Learning Disability CTT	Sunderland Older Adult Day Service	Behaviour Support Service	Sunderland Older Adult CTT

Inpatient Care Group Provision



Inpatient Care Group – North Cumbria

Peer Support Provision

Edenwood Peer Support: WTE 1.0	Oakwood Peer Support: WTE 1.0	Rowanwood Peer Support: WTE 1.0	Ruskin Peer Support: WTE 0.91
Yewdale Peer Support: WTE 0.89	Hadrian Senior Peer Support: WTE 1.0		

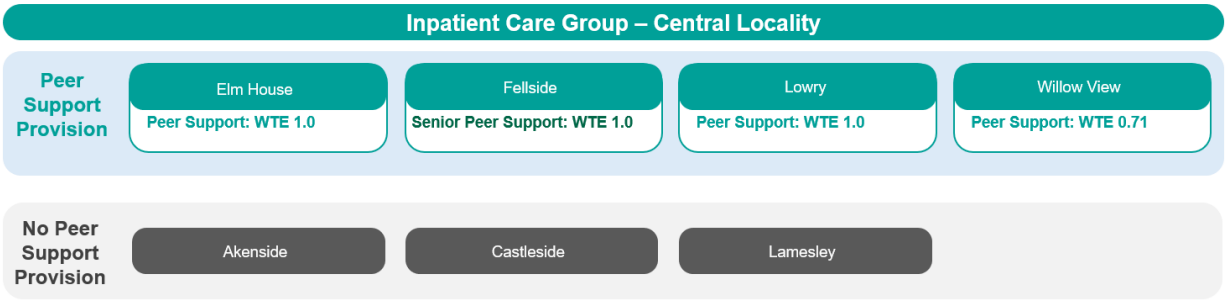
Inpatient Care Group – North Locality

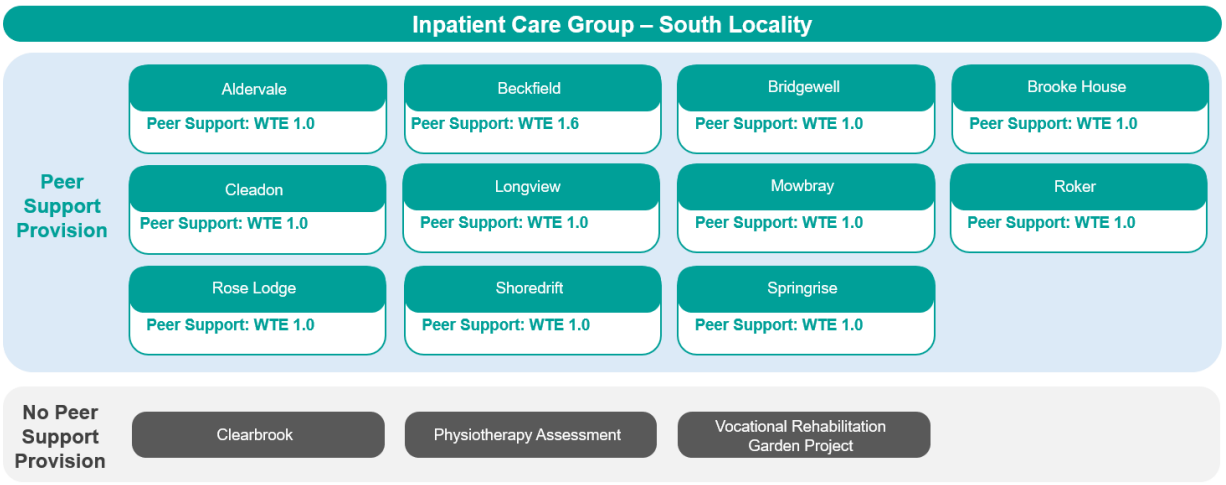
Peer Support Provision

Bluebell Peer Support: WTE 1.0	Embleton Peer Support: WTE 2.0	Hauxley Peer Support: WTE 1.0	Kinnersley Peer Support: WTE 1.0
Newton Peer Support: WTE 1.0	Warkworth Peer Support: WTE 1.0	Woodhorn Peer Support: WTE 1.0	

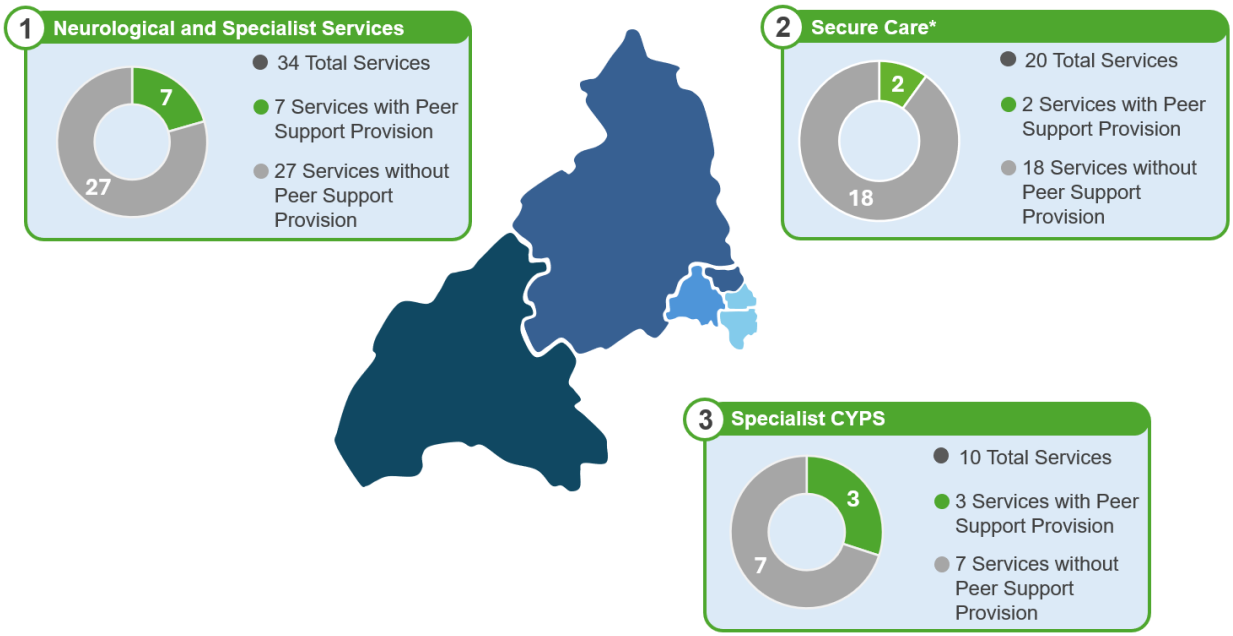
No Peer Support Provision

Alnmouth





Specialist Care Group Provision



Specialist services are Trust wide in respect of mapping. *Secure Care has four Peer Supporters in post in two services however they work into more than one service.

Specialist Care Group – Neurological and Specialist

Peer Support Provision

- Beadnell Mother and Baby Unit — Peer Support: WTE 1.0
- Community Adult Eating Disorder Service — Peer Support: WTE 1.0
- Northern Region Gender Dysphoria Service — Senior Peer Support: WTE 2.6
- Northumberland Recovery Partnership — Senior Peer Support: WTE 2.0
- Perinatal Community Mental Health Services — Senior Peer Support: WTE 0.8, Peer Support: WTE 1.2
- Regional Affective Disorder Inpatient Service — Peer Support: WTE 1.0
- Regional Affective Disorder Outpatient Service — Peer Support: WTE 0.6

No Peer Support Provision

- Centre for Specialist Psychological Therapies
- Community Acquired Brain Injury Service
- Community Multiple Sclerosis Team
- Helping Overcome Personal and Emotional Difficulties Team
- Neuropsychiatry Outpatient Team
- Neurorehabilitation Outpatients
- Newcastle Treatment and Recovery
- North Cumbria Adult Community Eating Disorder Service
- North-East Drive Mobility
- North-East Mental Health and Deafness Service
- North of Tyne Alcohol Detoxification Service
- North Tyneside Recovery Partnership
- Northumberland Head Injuries Service
- Personality Disorder Hub Service
- Regional Communication Aid Service
- Regional Disability Team
- Regional Environmental Control Service
- Richardson Eating Disorder Intensive Day Service
- Social, Therapeutic and Recreational Rehabilitation Team
- Mitford Inpatient
- Mitford Bungalows
- Northumberland Learning Disability CTT
- Northumberland Learning Disability Physiotherapy
- Ward 1 - Neuro-Behavioural Inpatients Specialist Rehabilitation
- Ward 2 - Neuro-Psychiatry Inpatients Adult Assessment and Treatment Unit
- Ward 3 - Neuro-Rehabilitation Inpatients Highly Specialist Rehabilitation
- Ward 4 - Neuro-Rehabilitation Inpatients Highly Specialist Rehabilitation

Specialist Care Group – CYPS

Peer Support Provision

- Redburn — Peer Support: WTE 1.85
- Stephenson — Senior Peer Support: WTE 1.0
- The Riding — Peer Support: WTE 0.84

No Peer Support Provision

- Community Eating Disorder Services North of Tyne
- Community Eating Disorder Services South of Tyne
- Complex Neurodevelopmental Disorders Service for Children
- Forensic Child and Adolescent Mental Health Service
- Intensive Positive Behavioural Service Community Team
- Lotus Ward
- Specialist Adolescent Mood Disorders Service

Specialist Care Group – Secure Care

Peer Support Provision

- Social, Therapeutic and Recreational Rehabilitation Team — Peer Support: WTE 2.4
- Secure Outreach Transitions Team — Senior Peer Support: WTE 1.0

No Peer Support Provision

- Alwinton Ward
- Berwick Ward
- Community Forensic Transitions Team
- Criminal Justice Liaison and Diversion Service
- Elsdon Ward
- Forensic Learning Disability Outreach Clinic
- Harthope Ward
- HMP Frankland Prison In Reach Forensic Service
- Linhope Ward
- Macmillan Nurse Palliative Care Service
- Offender Personality Disorder Service
- Rothbury Ward
- Specialist Community Forensic Team
- Tweed Unit
- Tyne Unit
- Westbridge Forensic Hostel Facility

Key issues, significant risks, and mitigations
Disparity of Peer Support Supervisor resource is having an adverse effect on the well-being and resilience of peers who are unfortunately no longer receiving regular lived experience supervision. Operational care groups are considering a reallocation of the supervisor resource which would reflect the number of Peer Supporters in each of the care groups.

Where there are gaps in the peer support offer across operational care groups, service users may not have equal access or opportunity to meet with people who have a shared experience of diagnosis, care or cultural background; considered as a positive aspect of a wider self-management.

Peer Supporters working in an acute setting are more likely to 'burn-out' or become unwell due to the nature of the environment.

5.2 Peer Support Joint Working Protocols

To provide a meaningful effective peer support offer, the Trust must consider and have in place robust mechanisms for recruitment, induction, training and development, support and supervision and a role structure. A Peer Support Joint Working Workgroup of Lived Experience Service, Workforce, Equality and Diversity, and Recruitment staff alongside operational managers and Peer Supporters, has been co-developing a robust policy document that will provide key procedural guidance for the recruitment, induction, development, employment and support pathways for all lived experience employees.

A co-produced 'Lived Experience Portfolio', designed to guide lived experience employee development throughout their career, has been piloted over the past year and was reviewed by the Joint Working Workgroup. The portfolio includes a competence framework for Band 3 Peer Supporters which is designed to be undertaken in the Trust's probationary period.

This group will also review Peer Supporter job descriptions to ensure they align with the skills portfolio and provide a clear definition of roles and responsibilities, including the needed resilience, capabilities and skills to meet the requirements of the role.

Key issues, significant risks, and mitigations
The Trust has a responsibility to provide support to those with lived experience who are being asked to work in services which may at times adversely affect their own well-being. This is more of a risk in an acute setting where 'burn-out' has been recognised, and best practice would be to have two peers working together in this setting to provide the additional support needed.

6. Summary Recommendations

Meaningful involvement of people with lived experience is achieved through inclusive practice, the support for service users, carers, and staff to work together is vital, this should not be compromised. The details provided in this report offer demonstrable evidence of continuing inclusivity through progressive and innovative working.

a. Triangle of Care

The Trust continues to hear about issues through inquiries and investigations, of carers who were not appropriately supported, listened to or included in the care of service users.

a. Ownership and regular oversight at a more senior level within the operational care groups is recommended to meet the requirements for Triangle of Care accreditation.

b. Triangle of Care Sub-groups reporting to Quality Standards Groups should be in place in all operational care groups.

c. Triangle of Care action plans and Carer Awareness Training should be included as quarterly agenda items for monitoring performance at Quality Standards groups, which will provide greater assurance on performance improvements.

d. A Dashboard system for Triangle of Care performance analysis is recommended to support the accurate reporting of operational services performance.

e. Carer Awareness Training is recommended for mandatory training to ensure staff value the role of carers and their instrumental role in better health care outcomes.

b. Service User and Carer Reference Group

The Service User and Carer Reference Group can be more fully utilised by operational care groups and corporate services to inform and share good practice, evaluate and improve service delivery, and involve the lived experience voice in co-creation from the outset of new projects.

a. Operational care groups, corporate services and project leads should ensure key national and local issues are being considered for representation at the Service User and Carer Reference Group.

c. Meaningful Involvement at a Local Level

a. In line with the views of the Service User and Carer Reference Group and Trust Leadership Forum, structured networks should be put in place by care groups for lived experience engagement forums at a local level.

d. Peer Support Workforce

There is national recognition that peer support provided by someone with lived experience who has recovered or is in a stable state from their own condition may improve the quality of life and experience of people. Where there is no peer support provision, service users may not have equal access or opportunity to meet with people who have a shared experience of diagnosis, care or cultural background considered as a positive aspect of a wider self-management.

a. Consider recruitment of Peer Supporters where there are gaps in the peer support offer across operational care groups. There should be a robust peer support offer in Early Intervention Psychosis (EIP) as identified in the 'Independent investigation into the care and treatment provided to VC – January 2025'.

b. Operational care groups should urgently consider a reallocation of the supervisor resource which would reflect the number of Peer Supporters in each of the care groups.

c. There should be a minimum of two Peer Supporters working together in an acute inpatient setting for their additional support against environmental triggers and 'burn-out'. Additionally, there should be support for a move from an acute inpatient setting to another service or care group where a Peer Supporter indicates that the environment is having a detrimental impact on their well-being.

Alane Bould
Associate Director for Lived Experience

Sarah Rushbrooke
Executive Director of Nursing, Therapies and Quality Assurance

31 March 2025

6.2 CHARITABLE FUNDS COMMITTEE UPDATE

Vikas Kumar, Committee Chair

7. GOVERNANCE AND REGULATORY

Darren Best, Chair

7.1 AUDIT COMMITTEE ASSURANCE REPORT

Robin Earl, Audit Committee Chair

REFERENCES

Only PDFs are attached

7.1 Audit Committee Assurance report to Board - April 25.pdf

Report to the Board of Directors
30 April 2025

Audit Committee Quarterly Assurance Report
Quarter 4 report (January 2025 – April 2025)

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus for the Audit Committee. This includes an overview of the areas of focus, discussion and assurance and the risk management framework for the Trust.

2. Audit Committee overview

The Committee is a statutory committee of the Board of Directors for the Trust and is a standing committee for the NTWS Ltd Board of Directors. It provides assurance to the Board that effective internal control arrangements are in place for the Trust and its subsidiary company. The Committee also provides a form of independent scrutiny upon the executive arm of the Board. The committee independently monitors, reviews and reports to the Board on the process of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

There have been two substantive meetings of the Committee during the period January 2025 – April 2025. Meetings were held on 4 February and 16 April. The Committee also held an Extra-ordinary meeting on 15 January to review and approve the Trust Charity Accounts.

3. Board Assurance Framework risks within Committee remit

The Committee has delegated responsibility for review of the adequacy and effectiveness of the overall management of principal risks through oversight of the Board Assurance Framework (BAF) and compliance with and effectiveness of the Risk Management Policy and processes. As such, the Audit Committee reviews the BAF in its entirety, following meetings of all other Board Committees.

It was agreed that plans should be developed to arrange a suitable date for the Audit Committee and the Board to review the Trust risk appetite, including the dates for achieving target risk scores for strategic risks.

Since the April was held, the Annual Internal Audit on the BAF has been confirmed as receiving substantial assurance.

In terms of the wider, Trust wide risk management policy and processes, it was recognised that CNTW is making good progress of utilising the BAF, Corporate Risk Register and Trust wide risk registers to shape agendas, discussions, focus and line of sight on key issues, and decision-making across the organisation. The outcome of the Annual Internal Audit on Trust wide Risk Management is still to be issued at the time of writing.

The Committee discussed the proposal to recommend to the Board a reduced risk score in relation to 2548 relating to partnership working. The current score is 12 (a likelihood score of 3 likely to happen). The proposal is to reduce this to 2 – unlikely to happen. This is based on evidence and assurance of the strong relationships across the footprint and the development of tangible pieces of work with the North East and North Cumbria Integrated Care Board, Tees, Esk and Wear Valley NHS FT and the third sector (i.e., for development of Hope Haven).

4. Audit Committee focus January – April 2025

4.1 Issues relating to statutory and regulatory compliance and governance oversight

In February, the Committee reviewed the Trust Standing Financial Instructions and Scheme of Reservation and Delegation which included strengthening of reference to the relationship between the Trust and NTW Solutions Limited, particularly in relation to procurement of services and the requirement to produce consolidated accounts. Other changes included amendments to the Trust Investment Policy to assist with approval of bids and research contracts including a consistency change around the business change process.

The Committee reviewed Procurement Waivers during the period and noted that the Procurement Team were carrying out a sampling process to review assurance in this area. The outcome of the sample testing will be reported to a future meeting. In terms of assurance, the Committee noted the improved position on 'no purchase order, no pay' policy compliance.

The Committee received an assurance update on the process in place to support the Trust Freedom to Speak Up (FTSU) policy. There has been an increase in the number of FTSU Guardians in place with phased terms of office to ensure ongoing continuity and the Trust has implemented measures of support in terms of protected time to enable the Guardians to fulfil their role. FTSU detailed reports in terms of outcome, themes and actions are reported regularly to the BGD-Workforce meeting (for operational oversight) and the People Committee (for strategic oversight).

The Committee received assurance on the management of risks associated with Digital Infrastructure and received a detailed update in February on ongoing progress noting a good level of assurance in response to internal audit work relating to Wireless Network Security. In terms of disaster recovery planning, simulated exercises take place every month.

To ensure triangulation on quality, safety, people and resource risk management, the Committee continues to operate a cycle of assurance from other Board committees. In February, Brendan Hill, People Committee Chair and in April, Louise Nelson, Quality and Performance Committee Chair provided updates on their respective Committees and their approach to risk management and oversight of key issues within their terms of reference and delegated authority from the Board. A strong level of assurance from both updates was received.

An update was provided to the Committee regarding compliance with the process to respond to CQC visits, inspections and concerns. There were no significant concerns in this regard and the Quality and Performance Committee and Mental Health Legislation Committee continue to have strong oversight in this regard.

At the February and April meetings of the Committee, discussion has taken place on the importance of ensuring robust policy and processes are in place in relation to the management and oversight of Declarations of Interest and standards of business conduct. The Committee take this role seriously in the context of being a public benefit organisation and the associated roles and responsibilities to ensure high standards of conduct. The revised Declaration of Interest Policy was subject to detailed review and low compliance of completion of DOI submissions from the medical workforce was noted. An addendum to the policy and process has been developed to support the medical workforce to encourage submissions to be made in a timely way. The Committee agreed that the policy, process, communication plan and systems to support DOI submissions and oversight was robust.

The Committee received notification of gaps in process around compliance checks associated with patient monies and patients' property since the pandemic. A report was received outlining the plan and actions to be taken to reinstate processes from May. A request has been made to

the internal audit team to incorporate an audit on the reinstatement of processes to provide future assurance.

4.2 External Audit

Concerns were noted by the Committee regarding the timeliness of the Charity Accounts Annual Audit resulting in completion of the audit being later than anticipated. The Committee received a commitment that plans were in place to ensure earlier turnaround of information and draft reports to be presented to the committee in future.

The Committee noted the first stage of a Financial Reporting Council (FRC) review regarding the lack of competition within the audit market. A number of areas are being considered nationally and regionally including using a second tier of audit firms and collaborative procurement. It should be noted that the local audit market has been in a vulnerable position for several years and the ongoing shortage of sufficiently qualified experts to carry out audit work and meet the requirements of regulators. The Committee will monitor developments in this area closely but noted that Mazars, the Trust External Auditor had been appointed in June 2024 therefore, this did not pose an immediate risk to the Trust.

The Audit Strategy memorandum for the year ended 31 March was presented to the Committee. The report outlined the audit approach, significant audit risks and areas of key judgement identified.

4.3 Internal audit and internal control issues and areas of focus

As of April, from the 2024/25 Internal Audit plan, 18 final reports and three draft reports have been issued with 11 audits in progress (three of which, the fieldwork is complete with draft report pending). The Internal Audit Team advised that delivery of the whole plan is scheduled to be complete by the 30 June 2025. Concerns were raised regarding the number of overdue audit recommendations and steps being taken to address these, particularly long-standing recommendations.

During the period, one substantial assurance report, six good assurance reports and two reasonable assurance reports were issued. One report received limited assurance relating to a follow up audit on Duty of Candour. This report will be reviewed in detail at the next Audit Committee (to gain assurance on the progress to complete the recommendations), and Quality and Performance Committee (to gain assurance on key areas of work for improvement).

The Committee received the Local Counter Fraud progress report which provided strong assurance in terms of progress against the annual work plan.

4.4 Other issues and assurance received by the Committee

During the period, the Committee also received the following reports:

- Terms of reference review (submitted to the April Board meeting for approval).
- Audit Committee cycle of business review (continues to reflect the terms of reference and the requirements of the NHS Audit Committee handbook).
- Annual effectiveness review outcome (confirmation that the Committee continues to work effectively).

5. Ongoing areas of focus for the Committee

Future areas of focus for the Committee for quarter 1 2025/26 (April – June) will include updates on outstanding actions relating to spend analysis, confirmation of the communications plan for

out of hours incidents, and the effectiveness of processes for the management of patient monies and patients' belongings. The key area of future during May and June will be oversight, review and assurance on the Trust Annual Report and Accounts for 2024/25.

Ongoing review of compliance with submission of Declarations of Interest in relation to the medical workforce.

Summary and recommendation

The Board is asked to note the content of the report and seek further assurance on any issues where appropriate.

The Board are asked to **consider and if appropriate approve** the recommendation to reduce the risk score in relation to 2548 relating to partnership working and consider whether to de-escalate the risk to the Chief Executive Directorate risk register or maintain the risk on the BAF for continual oversight.

The Board are asked to **support** the proposal to arrange Board time at a future development session to review the Trust Risk Appetite.

The Board are asked to **approve** the terms of reference for the Committee (under cover of Board agenda item 7.4).

Robin Earl
Chair of Audit Committee
April 2025

7.2 TRUST ANNUAL PLAN 2025/26 (AND QUALITY PRIORITIES FOR 2025/26) - FOR APPROVAL

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

7.2 Board - Planning Paper 2025-26 FINAL.pdf

Meeting	**Board of Directors**		**Agenda item: 7.2**
Date of meeting	30 April 2025		
Report title	Trust Annual Plan 2025/26 (and Quality Priorities for 2025/26) - for approval		
Report Lead	Kevin Scollay – Executive Director of Finance		
Prepared by	Chris Cressey – Deputy Director of Finance Tommy Davies – Deputy Director of Transformation, Delivery and Performance		
Purpose	**For decision**	**For assurance**	**For awareness**
		x	
Report previously considered by	The Trust plan has been considered by Trust Board, RABAC, Executive Management Group and Trust Leadership Forum. • 15/01/2025 – Trust Board Away Day - Initial planning • 27/01/2025 - Executive Management Team – oversight of initial plan • 31/01/25 – RABAC – detailed overview of the plan • 05/02/2025 – Board of Directors - review of the plan • 12/02/2025 – Trust Leadership Forum – feedback/oversight of the plan • 19/02/2025 – Board of Directors (extraordinary) – approval of the draft plan • 19/03/2025 – Board of Directors (extraordinary) – approval of final plan		
Executive summary	**Context** The purpose of this report is to provide a brief of the key priorities underpinning the trust's submitted annual plan for 2025/26. The NHS's strategic focus includes balancing finances, promoting transparency, and prioritising quality, access, and population health through devolved accountability and a leaner system with no expectation of further planning guidance this year. The 10-Year Health Plan and spending review will set the groundwork for medium-term planning. The Trust and ICBs submitted aligned 2025/26 planning submissions addressing finance, productivity, workforce, and performance.		

	Focus of the paper • Guided by the Trust "With You in Mind" strategy, and national priorities, a set of Trust priorities have been produced for the year across the five ambitions. • An overview of the Trust financial plan that was received by RABAC. • A diagram and description for the oversight and assurance of the plan. • The plan is underpinned by our Model of Care and Support. See Appendix 1.
Detail of corporate/ strategic risks	The Trust plans cover all aspects of Trust Business and therefore they are related to most of the BAF risks as per the below: Board Assurance Framework risk 2457 – Trust not considered a good partner, 2510, Risk of not meeting regulatory and statutory requirements. Board Assurance Framework risk 2511 – Failure to embed a safe learning culture Board Assurance Framework risk 2512 – Failure to deliver our transformation plans around the model of care Board Assurance Framework risk 2542 – Failure to deliver a sustainable workforce model. Board Assurance Framework risk 2542 – Risk of poor wellbeing of staff, 2545 – Failure to deliver sustainable financial position Corporate Risk Register risk 1687 – Managing resources effectively Corporate Risk Register risk 1762 – Restrictions in capital expenditure
Recommendation	The Trust Board are asked to approve the annual plan as described in the paper
Supporting information / appendices	Not applicable

2025/26 Planning

Contents

Executive Summary

- The purpose of this report is to provide an overview of the annual plan for 2025/26 for ratification and to provide a summary of the process for oversight and assurance for the plan. While focussed on 2025/26, many priorities will extend across financial years, ensuring sustained progress and the ongoing embedding of improvements.

- National Guidance and Focus:
    - Finalise plans to balance the books and deliver operational imperatives
    - Greater transparency, fair shares allocation, and devolved accountability
    - Shift leadership energy from deficit reduction to quality, access, and population health

- Strategic Direction for NHS and Providers - Moving to a different way of working together as leaders:
    - 10-year Health Plan and spending review due out this Spring will set the foundations to prepare for a medium-term planning approach
    - Remove the need for further planning guidance this year
    - Focus on a more devolved, rules-based system that is built on strong Board accountability
    - ICBs to lead as strategic commissioners within a leaner system
    - Need to invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management and contracting
    - Need to commission and develop neighbourhood health, with the delivery being a provider function over time (GPs, PCNs, community and mental health trusts, social care, acute trusts or others)

- The Trust has submitted its 2025/26 operational plan to the ICB in March, which included plans for finance, productivity, workforce, and performance/activity.

- All Integrated Care Boards (ICB) are required to submit their annual plans for 2025/26 to NHS England. The North East & North Cumbria submitted the relevant planning documents to NHS England by the deadline of 27th March 2025. The ICB annual plan includes the plans for all NHS providers within their system. All providers are required to submit a performance, productivity, workforce and financial plan to the ICB.

- A set of Trust priorities for 2025/26 have been developed, based on the organisational strategy ‘With you in Mind’ considering local need and national priorities.

- An overview of the Trust financial plan that was received by RABAC. The trust planned efficiency of £30.6m has been submitted with a risk rating.

- The Trust will provide executive oversight and board assurance for the delivery of the Trust plan, including the core priorities under each ambition, as well as finance, productivity, performance, workforce, and transformation programmes using the framework described in the oversight and assurance section of the report.

- The plan is underpinned by our Model of Care and Support. See **Appendix 1**.

Financial Plan Summary

The trust planned efficiency of £30.6m has been submitted with a risk rating. The efficiency plan includes £7.3m (24%) rated high risk, £8.6m (28%) rated medium risk and £14.7m (48%) rated low risk. On submission of the plan within the £7.3m rated high risk £2.1m of the total still required schemes to be developed. The trust has since recognised schemes of £1.3m of mitigation and continues to identify schemes to reduce the risk to delivery.

	£m	
High	7.3	24%
Medium	8.6	28%
Low	14.7	48%
Efficiency	**30.6**	**100%**

The capital allocation for CNTW for 2025/26 has been increased to include benefits from delivery of a surplus for 24/25. The trust plan is compliant with the Capital Department Expenditure Limit (CDEL) allocation from the ICB of £10.9m.

The trust plan will result in a reduction in the trust cash balances of £15m to £20.5m at the end of 2025/26. The plan includes non-cash transactions supporting the I&E position and the trust capital programme is greater than the level of deprecation generated and external funding. The trust also has commitments to service for PFI and Department of Health loans.

2025/26 Trust Priorities

The trust has five key ambitions from the Strategy ‘With You In Mind’ which underpin the annual priorities for 2025/26.

- Ambition 1 – Quality Care every day.
- Ambition 2 – Person Led care when and where it is needed.
- Ambition 3 – A great place to work.
- Ambition 4 – Sustainable for the long term and innovating every day.
- Ambition 5 – Working with and for our communities.

Ambition 1 – Quality Care every day

Draft quality priorities for 25/26 are summarised in the diagram below. These quality priorities, recently shared with the Service User and Carer Reference Group, will now be considered during a period of consultation. The priorities build on the work we have taking forward during 24/25 on the PSIRF priorities as well as the key themes of learning arising from the safety incidents we have had during the last twelve months.

Ambition 1 | Quality care, every day

Priority
Develop a consistent and evidence -based approach to risk assessment and safety planning across all services.
Promote care planning that is person -centred, co-produced, and informed by the multidisciplinary team.
Strengthen communication with families and carers, ensuring they are actively involved in care decisions and when a patient deteriorates.
Improve the accuracy, relevance, and timeliness of clinical record keeping to support safe, effective care.
Enhance assertive engagement with people who have (SMI) Severe Mental Illness, improving access and continuity.
Reduce waiting times and improve the experience and management of patients on waiting lists.
Ensure safe and coordinated transitions between services.
Improve the early recognition and response to deteriorating patients
Continue to improve sexual safety by reducing incidents and strengthening prevention and response.
Deliver and embed the Trust's 10 high impact actions in inpatient settings with clear outcomes.
Manage and reduce the risk of cardiorespiratory arrest caused by sedative medication
Manage and reduce the risk of severe clozapine -induced constipation
Support staff wellbeing through increased access to resources, compassionate leadership, and healthy workplace culture.

Ambition 2 | Person led care when and where it is needed

Priority
Develop Intensive Case Management to improve care for individuals with Severe Mental Illness
Implement and continue to develop the Trust's New Model of Care and Support and facilitate a transition away from the Care Programme Approach.
Develop a strong interface between Crisis, Community, and Inpatient services to effectively meet patients' needs during a crisis
Successfully deliver and sustain the Hope Haven 24/7 Neighbourhood Health Centre as part of the government flagship Neighbourhood Health approach.
Collaborate with TEWV, Primary Care, VCSE, and other partners to design a significantly different pathway for ADHD and Autism Spectrum Disorder needs.
Work with partners on the implementation of Inpatient Quality Transformation: • Reconfigure Inpatient services to optimise the estate to have the maximum impact on the quality and safety of patient care. • Increasing the availability of senior decision makers over a 7-day period. • Ensuring purposeful admissions, therapeutic care and effective discharge. • Fully multidisciplinary, skilled and supported workforce. • Joined up partnerships, personalised care with shared decision making that is trauma informed and advance health equality.
Develop, agree and progress the implementation of a new model of care for the Mitford Unit Autism Spectrum Disorder Inpatient Unit.
Redesign and improve the pathway for specialist children and young people's eating disorder services
Implementation of a new Psychosis Review and Community Clozapine Initiation Service (PRECCIS)

Ambition 3 | A great place to work

Priority
Continuing work on culture and leadership, including embedding of trauma informed and just culture principles in workforce policies and practices
Supporting organisational change as identified in the annual plan
Embedding sexual safety legislation and practice to create a safe working environment for staff
Supporting staff to remain well at work and provide early intervention support to prevent/reduce sickness absence.

Ambition 4 | Sustainable for the long term and innovating every day

Priority
Deliver a £3.3m surplus in 2025/26 as part of the North-East & North Cumbria ICB's plan for financial break-even.
Address financial deficits across NHS providers in the system, ensuring alignment with the ICB's surplus targets for break-even.
Deliver the £30.6m efficiency plan by mitigating high-risk areas (£7.3m), including identifying and developing schemes for the remaining £2.1m, while reducing overall delivery risks.
Mitigate financial risks, currently identified at £7.3m, with actions to reduce exposure and increase mitigation measures.
Maintain compliance with ICB Capital Department Expenditure Limits (CDEL) for 2025/26 through disciplined capital planning.
Ensure positive cash balances while developing surpluses in future years to replenish cash levels.
Focus on medium-term sustainability by reshaping the Trust's planning horizon.
Achieve medium-term financial sustainability over three years by improving service delivery in collaboration with the ICB.

Ambition 5 | Working with and for our communities

Priority
Implement our approach to PCREF (Patient and carer race equality framework) and health inequalities
Continue to develop our partnership and collaboration with TEWV NHS FT.
Continue to work with our communities, primary care partners, local authorities and third sector partners across our places on community mental health transformation.
Support the changes across the system in relation to the work across the integrated care board and NHS regional teams.
Effective partnering with acute and ambulance trusts to better integrate physical and mental healthcare, focusing on eating disorders and emergency departments
Embed learning through collaborative research and informing improvements together in care delivery
Embed the implementation of the together strategy that has been developed and adopted by the service user and carer reference group.

Oversight and Assurance

The Trust will provide oversight and assurance for the delivery of the Trust plan, including the core priorities under each ambition, as well as finance, productivity, performance, workforce, and transformation programmes, through the process described in the diagram below.

Period	Purpose	Reporting / Assurance / Oversight	Meetings
Monthly	Oversight of operational delivery, oversight/assurance of risks, drive improvement against transformation programmes, priorities and measures. Escalate only in exceptions to Closed Board for assurance	Care group/Executive Oversight - Care Group Delivery - Programme Delivery Reports - Finance Reporting - Trust IPR - EMG Board Assurance - Closed Trust Board by exception	Care group/Executive Oversight - Care Group OMG - Business Delivery Group - Programme Boards - EMG Board Assurance - Closed Trust Board
Quarterly	For executive oversight and board assurance, report on the progress with the priorities within the 5 key ambitions, assurance against risks and delivery on Transformation Programmes	Executive Oversight - Well Led Care Group delivery - Programme delivery - EMG Board Assurance - RABAC - Ambition 4 / Risk - Q&P Cttee - Ambitions 1,2&5 - People Cttee Ambition 3 - Trust Board - All ambitions/risk assurance/IPR	Executive Oversight - Well Led Care Group Meetings - EMG Board Assurance - RABAC - Quality & Performance Cttee - People Committee - Trust Board Meeting

Figure 1: Planning oversight and assurance framework diagram

Monthly

Executive Oversight

Oversight of the plan on a monthly basis is through the Care Group Operational Management Groups, Programme Boards, Business Delivery Group and Executive Management Group. Reports on finance, risks programmes, integrated performance (IPR) and care group delivery will flow to these groups for executive oversight.

Board Assurance

On a monthly basis only if necessary for the months in between the quarterly reports, the Closed Trust Board will receive an update regarding risks or significant issues and only by exception.

Quarterly

Executive Oversight

Executive oversight on a quarterly basis includes care groups and executive management team Well Led meetings and reporting oversight to the Executive Management Group. This includes progress against all of usual monthly reports and in

addition, progress against the wider trust plan including the priorities set out against the five strategic ambitions.

Board Assurance
The Board will receive assurance through a summary of key monthly reported areas by exception, alongside progress against the Trust plan, including priorities set out against the five strategic ambitions.

Committee Reporting:

RABAC will review reporting for assurance against the plan on sustainability.

Quality and Performance Committee will review assurance against the plan on Quality, Person-Led Care, and Working With and For Our Communities.

People Committee will review assurance against the plan on creating a Great Place to Work.

Trust Board:

Will receive a comprehensive reporting summary across all areas, including assurance against risks, transformation programme delivery, and the Trust plan.

Appendix 1

Model of care and support

Help and treatment for people with mental health and wellbeing needs, learning disability, neurodivergence, or neurological disorders.

7.3 BOARD ASSURANCE FRAMEWORK / RISK MANAGEMENT REPORT

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

7.3 BAF Report for Board - April 2025.pdf

Meeting	**Board of Directors**		
Date of meeting	30 April 2025		
Report title	Board Assurance Framework (BAF)/risk management report		
Report Lead	Debbie Henderson, Director of Communications and Corporate Affairs		
Prepared by	Debbie Henderson, Director of Communications and Corporate Affairs		
Purpose	**For decision**	**For assurance**	**For information/ awareness**
	x	x	
Report previously considered by	• Quality and Performance Committee • Resource and Business Assurance Committee • People Committee • Audit Committee		
Executive summary	The Board Assurance Framework has been subject to review by all Board Committees during April 2025. All Committees were satisfied that the BAF continued to reflect appropriately the risks to the achievement of the Trust Strategic Ambitions. All Committees were satisfied that the risks were being managed appropriately and received assurance that risks were subject to ongoing active review. The Audit Committee reviewed the BAF in its entirety at its meeting held 16 April to gain assurance on the robustness of the risk management process. The Committee was satisfied that appropriate controls were in place reflecting the Trusts approach to risk management and that internal audit planning continued to reflect the key risks and challenges facing the organisation. The Committee reviewed a recommendation to reduce the risk score in relation to risk 2548 in relation to partnership working and were satisfied that appropriate evidence and assurance was in place to justify a reduction in the risk score. The current risk score is 12 (likelihood score of 3 possible x impact score of 4 significant). The proposal is to reduce the score to 8 (likelihood score of 2 unlikely x impact score of 4 significant). The final Internal Audit report of the BAF from AuditOne has given a substantial assurance with no findings or recommendations raised.		
Recommendation	The Trust Board are asked to receive the Board Assurance Framework update and assurance from Committees. The Board are asked to consider and approve the reduction in the risk score for risk 2548 relating to partnership working.		
Supporting information / appendices	Full Board Assurance Framework is available to Board members on request.		

Board of Directors

Board Assurance Framework (BAF)/Corporate Risk Register (CRR) Report
30 April 2025

1. Key definitions

Board Assurance Framework – contains a record of the risks to achieving our Strategic Ambitions. This is held by the Board of Directors and its committees. Risk Owners are the Executive Directors.

Corporate Risk Register – contains a record of the most significant operational risks across the Trust. This is held by the Executive Management Group. Risk owners are the Executive Directors.

Trust wide risk register – contains a record of operational risks currently being managed across the Trust. This includes risks held at ward/service level, Clinical Business Unit/Speciality level, directorate/group level. This is held at Business Delivery Group-Risk.

2. Overview and context

Understanding risk management is fundamental in a successful Organisation and is 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 gain 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 aligned to their sphere of responsibility.

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. The purpose of this report is to provide an update on the position of the BAF. A copy of the full BAF was reviewed by the Audit Committee at its meeting held 16 April. BAF risks aligned to specific Boards Committees were also reviewed at their most recent meetings held in April.

A brief, at a glance summary of the BAF and movement since the previous report is below.

Board Assurance Framework – summary (January 2025 – April 2025)				
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**	**Board Committee oversight**
Risk 2510 – 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.	Yes	No Remains as 4 X 4 = 16	- Additional control/assurances – Internal Audit report Capacity to Consent to Treatment Inpatients (detained under the MHA) – good level of assurance - Additional control/assurance – Internal Audit report Responding to Important Public Health messages and other safety critical information and guidance – substantial assurance. - Actions complete – 13092	Quality and Performance Committee
Risk 2511 – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.	Yes	No Remains as 3 X 5 = 15	No changes since previous report (February)	Quality and Performance Committee
Risk 2512 – Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern.	Yes	No Remains as 3 X 4 = 12	No changes since previous report (February)	Quality and Performance Committee
Risk 2543 – Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services.	Yes	No Remains as 3 X 4 = 12	- Actions complete – 16604	Quality and Performance Committee
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.	Yes	No Remains as 4 X 4 = 16	- Actions complete – 142877 and 14286	People Committee

Board Assurance Framework – summary (January 2025 – April 2025)				
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**	**Board Committee oversight**
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.	Yes	No Remains as 3 X 4 = 12	- Actions complete – 13540, 14290, 14291 and 14292	People Committee
Risk 2545 – 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.	Yes	No Remains as 4 X 4 = 16	- Actions complete – 16802 - Four new actions added 16802, 16803, 16804 and 16805	Resource and Business Assurance Committee
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.	Yes	No Remains as 3 X 4 = 12	- Actions complete – 14329 - Actions added – 16976	Resource and Business Assurance Committee
Risk 2547 – 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.	Yes	No Remains as 3 X 4 = 12	No changes since previous report (February)	Resource and Business Assurance Committee
Risk 2548 – 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.	Yes	Yes Current score 3 X 4 = 12 **Proposed score** **2 X 4 = 8** **(reduction in the likelihood score**	- Four new controls and assurances added. Increasing strength in collaborative working with third sector, partners (TEWV) and the ICB in place with evidence of positive outcomes (i.e., service change delivery). - Proposal to reduce the risk score to 8 reflecting the reduced likelihood score of the risk from 3 (likely) to 2 (unlikely).	Board of Directors

3. Board Committee BAF risk review summary – January 2025 – April 2025

All Committees continue to review the risks aligned to their respective terms of reference and delegated authority. Aligned to the new Board Committee assurance reporting to the Board, Committee Chairs reflect on agenda items in the context of the Trust strategic ambitions and associated BAF risks. Included in the discussion for each agenda substantive item is a reflection on the level of assurance provided, the level of control and mitigations in place, actions being taken to manage issues, and any gaps in assurance and actions still to be taken.

The Committees also continue to distinguish between outstanding actions and mitigations which are within the Trust control, those which sit outside of the Trusts direct control but may require a level of influence and collaborative working, and those issues which need to be accepted and cannot be controlled nor influenced (i.e., changes to national policy/legislation).

The BAF risks remain as the last item on agendas for all Committees so that the Committee can look at the key risks holistically to ensure the Committee remains focused on the relevant issues. It is also used to identify potential gaps in Committee oversight.

Each Committee has also reviewed the Corporate Risk Register risks. These are the highest-level operational risks facing the Trust and are managed by Executive Directors through the Executive Management Group on a monthly basis. This gives Board Committees a ‘line of sight’ to issues which may require strategic intervention at a future date.

The Mental Health Legislation Committee has reviewed the need for a risk relating to the impact of the changes to the Mental Health Bill. The Committee felt at present, risks associated with this were being managed at the most appropriately level in the organisation but have agreed to regular review this on an ongoing basis.

No issues have been identified by Board Committees during the period, and all Committees feel there is appropriate oversight of the key issues, risks and challenges faced by the organisation, and that risks are being managed appropriately across the Trust.

4. Audit Committee summary and review

In line with the Trust Risk Management Policy, approved by the Board of Directors, the Audit Committee has delegated responsibility within its terms of reference to oversee the risk management system and gain assurances that there is an effective system of internal control across the Trust. As such, the Audit Committee reviews the BAF in its entirety which includes relevant updates from each of the Committees as appropriate.

The Committee recognised the active and ongoing management of the risks and its role in shaping agendas, focus and discussion at Committee level. A sense check was also undertaken with Internal Audit colleagues present at the meeting to ensure internal audit planning remained aligned to the key risks.

4.1 Recommendation relating to risk 2548

The Committee discussed the proposal to recommend to the Board a reduced risk score in relation to 2548 relating to partnership working. The current score is 12 (a likelihood score of 3 likely to happen). The proposal is to reduce this to 2 – unlikely to happen. This is based on

evidence and assurance of the strong relationships across the footprint and the development of tangible pieces of work with the North East and North Cumbria Integrated Care Board, Tees, Esk and Wear Valley NHS FT and the third sector (i.e., for development of Hope Haven).

4. Board Assurance Framework and Risk Management Annual Internal Audit

Annually, the Internal Audit team (AuditOne) undertakes an audit on the Trusts BAF and risk management processes. Following a significant period of review of the Trust risk management policy and process during the past 18 month, we requested that the BAF and risk management processes be subject to separate audits so that robust testing could be carried out.

The final Internal Audit report of the BAF from AuditOne has given a substantial assurance with no findings or recommendations raised. The Internal Audit report of the wider Trust risk management processes remains unknown.

5. Recommendation

The Committee is asked to:

- Discuss the content of the report.
- Gain assurance that the BAF risks are being managed effectively by the respective Committees and Executive leads.
- **Consider, and if appropriate, approve,** the proposal to reduce the risk score relating to risk 2548 – partnership working, from 12 to 8.

Debbie Henderson
Director of Communications, Corporate Affairs and Risk
April 2025

7.4 BOARD COMMITTEES TERMS OF REFERENCE

Debbie Henderson, Director of Communications and Corporate Affairs

- Quality and Performance Committee
- Mental Health Legislation Committee
- People Committee
- Audit Committee
- Resource and Business Assurance Committee
- Board of Directors

REFERENCES

Only PDFs are attached

7.4 Board and Committee ToR review - FOR APPROVAL.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 7.4**
Date of meeting	Wednesday 30 April 2025		
Report title	Board and Committee Terms of Reference Annual Review		
Report Lead	Debbie Henderson, Director of Communications and Corporate Affairs		
Prepared by	Debbie Henderson, Director of Communications and Corporate Affairs		
Purpose	**For decision**	**For assurance**	**For awareness**
	x		
Report previously considered by	All Board Committees have reviewed their respective terms of reference		
Executive summary	The terms of reference for the all Board Committees have been subject to annual review. A summary of the changes are detailed below: **Audit Committee** - Clarity on membership and quorum. - Inclusion of expected behaviours and conduct. - Expectation for the Chair and members to meet with internal and external audit colleagues out-with formal meetings. - Reference to reporting through the use of the assurance report. - Removal reference to the formal audit of data quality in the Quality Accounts. This has not been a requirement for a number of years and there is no expectation that it will be reinstated as a national requirement. **People Committee** - No change made. **Resource and Business Assurance Committee** - No change made. **Quality and Performance Committee** - Inclusion of the Director of Nursing, Mental Health, Learning Disabilities, Autism and Complex Care, NENC Integrated Care Board as an attendee. - Inclusion of ensuring the Trust has an effective system for clinical governance in place. - Removal of the Clinical Quality Governance Group as a sub-group. **Mental Health Legislation Committee** - Inclusion of Lynne Shaw, Executive Director of Workforce and Organisational Development as a member. - Inclusion of 'receiving assurance that systems, structures and		

	processes in place to ensure compliance with and to support the operation of Mental Health Legislation within inpatient and community settings, to ensure that any proposed changes to Mental Health Legislation are identified and monitored and necessary changes made to practice to comply and to ensure compliance with associated codes of practice and recognised best practice'. With the exception of Audit Committee, all Board Committees have included the following in the purpose section: "The Committee will oversee and monitor the ongoing work in relation to Health Inequalities relating to the business of the XXXXX Committee". The Board of Directors Terms of Reference has been amended to include the following statement: "The Board will take a holistic view of, and monitor, the ongoing work in relation to the delivery of work to address Health Inequalities"
Detail of corporate/ strategic risks	N/A
Recommendation	The Trust Board of Directors is asked to approve the revised Terms of Reference for the Board and Board Committees.
Supporting information / appendices	Appendix 1 – Terms of Reference for the Board and Board Committees.

Membership	
Chair:	Non-Executive Director
Deputy Chair:	Non-Executive Director
Membership:	Three Non-Executive Directors (including the Chair and Deputy Chair of the Committee). The Chair of the Trust will not be a member of the Committee. Committee Chair and Members are appointed by the Board of Directors of the Trust.
In Attendance:	The following Members will be expected to attend on a regular basis. - Executive Director of Finance - Director of Corporate Affairs and Communications/Company Secretary - Managing Director for NTW Solutions Ltd ("NTWS") - Internal Auditors (AuditOne) - Local Counter Fraud Services - External Auditors - Deputy Trust Secretary/Corporate Affairs Manager - Governor representative X 2 *Executive Directors and other Trust representatives will be expected to attend meetings at the request of the Chair* *The Chief Executive should also attend when discussing the draft Annual Governance Statement and the Annual Report and Accounts.*
Quorum:	Two Non-Executive Directors
Deputies:	Deputies are permitted to deputise for those in attendance No deputies are permitted for Non-Executive Directors

Purpose
Audit committee is a statutory committee of the Board of Directors for the Trust and is a standing committee for the NTWS Ltd Board of Directors. To provide assurance to the Board of Directors that effective internal control arrangements are in place for the Trust and its subsidiary companies. The Committee also provides a form of independent scrutiny upon the executive arm of the Board of Directors. The Accountable Officer and Executive Directors are responsible for establishing and maintaining processes for governance. The committee independently monitors, reviews and reports to the Board of Directors on the process of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes. This committee has been established to provide assurance to the Board of Directors on the Trust and its subsidiaries from a Group perspective. Assurances from this committee to Trust Board will also be shared with the NTWS Board of Directors, who have an established Risk, Assurance and Governance Committee, in order to specifically review and address these assurances from an NTWS perspective.

Governance, rules and behaviours
The committee is authorised by the Board of Directors:

- To investigate any activity within its Terms of Reference
- To obtain outside legal or other independent professional advice and secure attendance of outsiders with relevant experience and expertise it considers necessary
- Ensure that the Head of Internal Audit, representatives of External Audit and Counter Fraud specialists have a right of access to the Chair of the committee.
- Ensure compliance with NHS England's Code of Governance and NHS Audit Committee Handbook
- All Members and Attendees are expected to behave in accordance with Trust values.
- Attendees should adhere to meeting etiquette guidelines.
- The Corporate Affairs Team will provide administrative support to the Committee including production of agendas, minute taking, action logs, circulation of papers and arranging meeting dates.
- Papers should be circulated 5 working days in advance of the meeting.

Scope

Integrated Governance, Risk Management and Internal Control

Review the adequacy and effectiveness of the risk management system and obtain assurances that there is an effective system operating across the Trust for the identification, monitoring and control of risks. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust and subsidiary companies that supports the achievement of the organisation's objectives. In particular the committee will review the adequacy and effectiveness of:

- The Trust's Risk Management Policy and associated guidance.
- All risk and control related disclosure statements (i.e., the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors.
- The underlying assurance processes that indicate the degree of achievement of the organisation's strategic objectives and the effectiveness of the management of principal risks through oversight of the Board Assurance Framework.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certification, including oversight of compliance with the Trust's Standards for Business Conduct Policy.
- The policies and procedures for all work related to fraud as required by NHS Counter Fraud Authority.
- The work of Internal Audit, External Audit, local Counter Fraud Specialists and other assurance functions. It will also seek reports and assurances from Executive Directors and senior managers as appropriate.
- The development, monitoring and review of the Trust's Board Assurance Framework and assurance from other Board Committees that they are fulfilling their delegated responsibility for the management of associated risks.
- The Audit Committee's relationships with other Board Committees to ensure triangulation of issues relating to risk management and clinical and quality issues.

Internal Audit

Ensuring an effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

- Consideration of the provision of the Internal Audit function and the costs involved.
- Review and approval of the Internal Audit Plan, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework and other high-level risks identified in the Trust's Corporate Risk Register.
- Consideration of the major findings of Internal Audit work and ensuring co-ordination between the Internal and External Auditors.
- Ensuring that the function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

Counter Fraud

Ensuring adequate arrangements are in place for countering fraud and reviewing the outcomes of counter fraud work. This will be achieved by:

- Consideration of the provision of the counter fraud function and the costs involved
- Review and approval of the counter fraud strategy, annual work plan and the three-year risk based local proactive work plan.
- Consideration of the major findings of counter fraud proactive work, review of progress against plans and the annual report on arrangements.
- Ensuring that the function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of the counter fraud function and carrying out an annual review, taking into account the outcome of the NHS Counter Fraud Authority quality assessment of arrangements.

External Audit

The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular review the work and findings of the external auditors and consider the implications and management responses to their work. This will be achieved by:

- Discussion and agreement with the External Auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan.
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and impact on the audit fee.
- Reviewing all reports, including the reports to those charged with governance arrangements, including the annual management letter before submission to the Board of Directors and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Supporting the Council of Governors with their duty to appoint, re-appoint and remove the External Auditors as stipulated by NHS England's Code of Governance.
- Develop and implement a policy, with Council of Governors approval, that sets out the engagement of the External Auditors suppling non-audit services. This must be aligned to relevant ethical guidance regarding the provision of non-audit services by the External Audit firm.

Other Assurance Functions

Review the findings of other significant assurance functions, both internal and external to the organisation, and consider governance implications. These will include, but will not be limited to:

- Reviews by the Department of Health Arm's Length Bodies or regulators/inspectors (e.g. CQC, NHSLA, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).
- Review the work of other committees within the Trust at its Subsidiary Companies, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include the committee with the remit for clinical governance, risk management and quality
- In reviewing the work of the aforementioned committees, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Management

Request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. Request specific reports from individual functions within the organisation.

Financial Reporting

Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

Review the Trust's internal financial controls and review the Annual Report and financial statements before submission to the Board of Directors, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted miss-statements in the financial statements
- Significant judgements in preparation for financial statements
- Letter of representation
- Explanation for significant variances

Raising Concerns

The committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that such concerns are investigated proportionately and independently.

The Audit Committee Annual Report should describe how the committee has fulfilled its delegated responsibilities outlined in its Terms of Reference, and a summary following a review of its own effectiveness. It will also provide details of any significant issues that the committee considered in relation to the financial statements, key risks and how they were addressed along with other responsibilities specified in NHS England's Code of Governance.

Monitoring

The Committee will review its performance annually against its Terms of Reference and will report on the outcomes in its annual report to the Board.

Authority

The Committee independently reviews subjects within its Terms of Reference, primarily by receiving reports from the external auditor, internal auditor, local counter fraud specialist, management, and any other appropriate assurances.

The Chair and other Members can and should regularly meet Internal and External Audit providers separately from Committee meetings.

Deliverables

Assurance to the Board of Directors and, where applicable, to the Board of NTWS on the following:

Integrated Governance, Risk Management and Internal Control
The establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisations objectives.

Internal Audit
An effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Audit Committee, Chief Executive and Board of Directors.

Counter Fraud
That the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

External Audit
External Auditor's independence and objectivity and the effectiveness of the audit process.

Other Assurance Functions
The findings of other significant assurance functions, both internal and external to the organisation and the implications for the governance of the organisation are considered. That the work of other Committees within the organisation provide relevant assurance to the Audit Committee's own areas of responsibility. The clinical audit functions effectiveness in terms of providing assurance regarding issues around clinical risk management.

Management
The overall arrangements for governance, risk management and internal control, having regard to evidence and assurances provided by directors and managers and specific reports from individual functions within the organisation (e.g. clinical audit).

Financial Reporting
The integrity of financial statements, systems for financial reporting, internal financial controls, the Annual Report and financial statements, including the wording of the Annual Governance Statement.

Annual Report and Accounts (including the Quality Account)
The draft Annual Report and Accounts (including the Quality Account) before submission to the Board of Directors for approval.

Raising Concerns
Effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and subsequent investigations.

Reporting
An Annual Report will be presented to the Board of Directors on its work in support of the Annual Governance Statement.

Any matters that the committee feel appropriate will be escalated to the Board of Directors. An assurance report will be provided to the Board of Directors (CNTW or NTWS Ltd) following every meeting and minutes will be formally recorded and will be provided to the board upon request.

Sub Groups
There are no sub-groups of the Audit Committee
Current review date: April 2025 **Date of Board approval: April 2025** **Date of previous review: June 2024**

People Committee
Terms of Reference

Committee Name	People Committee
Committee Type	Standing Committee of Board of Directors

Frequency	Quarterly (the Committee will hold 2 x development sessions per year to focus on key areas)
Committee admin	Corporate Affairs Team
Reporting arrangements	Report from Chair to Board of Directors Terms of Reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive Director
Vice-Chair	Non-Executive Director
Members	Executive Director of Workforce and Organisational Development Executive Director of Nursing, Therapies and Quality Assurance Executive Medical Director Chief Operating Officer Other Non-Executive Director (excluding Chair and Vice-Chair)
In Attendance	Deputy Director of Workforce and Organisational Development Equality, Diversity and Inclusion Lead Associate Director of Organisational Development Head of Workforce Development Associate Director – CNTW Academy Group Nurse Director Deputy Medical Director (revalidation) Director of AHPs and Psychological Services Governor representatives x 2
Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies required for all members by exception and with prior agreement of the Chair No deputies are permitted for Non-Executive Directors
Purpose	
To support the delivery of With You in Mind, the purpose of the Committee is to provide assurance to the Board with regard to workforce development and delivery of the Workforce strategy. It will hold the ambition of being the CNTW focal point for discussion and examination of the challenges and opportunities in workforce development that will better enable the Trust and its partners to help improve the mental health and well-being of the people we serve. The Committee will oversee and monitor the ongoing work in relation to Health Inequalities relating to the business of the People Committee.	
Scope	
The Committee will provide assurance to the Board with regard to workforce development and delivery of the Workforce strategy, enabling its programmes and plans to be delivered. In accordance with the ambitious purpose of the Committee, it will appropriately appraise the Board on how the Trust is influencing workforce development systemically with partners in line with the Trust's Strategy and by:	

- Supporting the strategic direction and monitoring implementation programmes for all workforce and organisational development issues and service delivery in line with the wider Trust strategic objectives.
- Providing assurance to the Board of Directors that the organisation is compliant with relevant legislation, appropriate external requirements and policies.
- Reviewing, assessing, and monitoring risks in line with the Trust Board Assurance Framework (BAF), ensuring appropriate assurance, mitigation and escalation is in place.
- Reviewing workforce key performance indicators.
- Ensuring the Trust remains focused on attracting, developing and retaining the right people with the right skills in the right place at the right time.
- Receiving assurance with regard to working collaboratively with Trust Operational Groups to set the direction of the overall workforce change programme.
- Providing a focus on workforce plans, workforce activity, role design, development and education, employee relations, health and well-being and people engagement across all staff groups.
- Overseeing and contributing to the benefits realisation of workforce initiatives and processes.
- Oversee the Health Inequalities agenda and implementation of Patient, Carer Race Equality Framework.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place to oversee the delivery of the Workforce strategy.

Deliverables

Assurance to the Board will be via:

- The successful implementation of the Workforce strategy and underpinning programmes and plans.
- Effective management of risk relating to the workforce portfolio providing assurance to the Board that effective controls are in place to manage workforce risks.
- Delivery of the Trust's action plans in relation to compliance, legislative and regulatory requirements relating to workforce.
- The implementation of the requirements of nationally agreed guidance.
- Compliance with relevant standards and key performance indicators relating to workforce.
- Successful programmes of work/initiatives identified from feedback of staff surveys and other indicators of staff experience, including themes and trends and updates on desired outcomes.
- Feedback from the Trust Freedom to Speak up Guardians.
- Implementation of agreed programmes of work relating to Health Inequalities, relating both to staff and wider communities.
- Feedback from other internal workforce forums.
- Progress of identified work from all standing sub-groups and delivery of any relevant programmes and plans.
- Feedback from staff Networks where appropriate.
- Ongoing progress on developing the organisational offer to support health and wellbeing programme and plans and providing assurance on the benefits of such schemes.
- Updates on the Trust Academy Programme and its contribution to the wider workforce strategy and organisational development plans.
- Progress on recommendations and actions resulting from Internal Audit outcomes relating to workforce and organisational development.

Sub Groups

Health and Wellbeing Steering Group
Health Inequalities Group

Equality, Diversity, and Inclusion Steering Group
Date of Committee review: February 2025 **Date of Board approval: April 2025** **Date of previous Board approval: June 2024**

Resource and Business Assurance Committee
Terms of Reference

Committee Name	Resource and Business Assurance Committee
Committee Type	Standing committee of the Board of Directors
Frequency	Quarterly

Committee admin	Corporate Affairs Team
Reporting Arrangements	Minutes and report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive Director
Deputy Chair	Non-Executive Director
Members	Executive Director of Finance Chief Operating Officer Executive Director of Nursing, Therapies and Quality Assurance Other Non-Executive Directors
In Attendance	Chief Information Officer Director of Estates, NTW Solutions Ltd Governor representative x 3 Deputy Director of Finance Locality Group Director
Quorum	A minimum of one Non-Executive Director (including the Chair or Vice-Chair) and a minimum of two Executive Directors.
Deputies	Deputies required for all members and those in attendance No deputies are permitted for Non-Executive Directors

Purpose

Provide assurance to the Board that:

- The Trust has effective systems and processes in place to secure economy, efficiency and effectiveness in respect of all resources, supporting the delivery of the Trust's Strategy and Operational Plans.
- There is a clear understanding of current and emerging risk to that delivery and that strategic risk in relation to the effective and efficient use of resources and the long term sustainability of the Trust and its services are being managed.
- The Trust has effective systems and processes in place for the management of risks pertaining to Provider Collaborative and Lead Provider Models.
- The Trust has an effective management of Provider Collaborative and Lead Provider Contracts, including the sub-contracts of the lead provider contracts and any partnership agreements.
- The Trust complies with the law, best practice, governance and regulatory standards which are within the Committee's scope.
- The Committee will oversee and monitor the ongoing work in relation to Health Inequalities relating to the business of the Resource and Business Assurance Committee.

Scope

- Review of arrangements for the development of the Trust Annual Resource Plan, ensuring that resources are adequately identified to meet quality and performance standards, or to highlight appropriate risks to the board
- Oversee the assurance delivery against the Trust's annual resource plan and the impact of in year delivery on key financial strategic risk.
- Oversee arrangements for financial reporting, cash management, internal control and business

planning to ensure that they comply with statutory, legal and compliance requirements and that they are developing towards best practice. Ensure that that there is a clear understanding of current and emerging risks and that actions are in place to maintain and continually improve the organisation's position as a high performing Trust for the use of resources.

- Oversee and assure the Trust's delivery of the Capital Programme in the light of service development plans, risk and quality issues, and in line with the Trust's Strategy and Operational Plans and the management of strategic risks.
- Oversee and assure arrangements for managing contractual relationships with Commissioners of services and ensure that there is a clear understanding of current and emerging risks.
- To oversee the development of significant investment and development proposals on behalf of the Board of Directors, including major projects, business case development, and tenders. Also to receive assurance on effective financial modelling for major tenders, effective project implementation and post project evaluation.
- Oversee and assure arrangements relating to the review the Trust's Commercial Investment Policy and Innovations Strategy.
- To receive assurance that proper arrangements are in place for the procurement of goods and services and that there is a clear understanding of current and emerging risks.
- To receive assurance that proper arrangements are in place for the management of the Trust's estate and that the infrastructure, maintenance and developmental programme supports the Trust's Strategy, Operational Plans and legal and statutory obligations. Ensure that there is a clear understanding of current and emerging risks.
- To receive assurance on the Trust delivery against its Green Plan and its overall response to the Climate and Ecological Emergency
- To receive assurance that proper arrangements are in place for the management of the Trust's Information Technology and Infrastructure, the Data Protection and Security Toolkit (DSPT), maintenance and development programme ensuring it supports the Trust's Strategy and Operational Plans, including delivery of improvement and efficiency objectives, and the fulfilment of legal and statutory obligations. Ensure that there is a clear understanding of current and emerging risks.
- To receive assurance that proper arrangements are in place to ensure delivery of sustainable healthcare, with a focus on productivity, benchmarking and the shift to early intervention and prevention
- To receive assurance that cash investment decisions are made in line with the Treasury Management Policy, and to review changes to this Policy, where appropriate.
- To receive assurance that appropriate arrangements are in place for insurance against loss across all Trust activities.
- Receive for assurance purposes routine reports from all standing sub groups and any other relevant reports/action plans in relation to current issues.
- Contribute to the maintenance of the Trust's Corporate Risk Register and Board Assurance Framework by ensuring that the risks that the Resource and Business Assurance Committee are responsible for are appropriately identified and effective controls are in place and that strategic risk in relation to the effective and efficient resources, and the long term sustainability of the Trust and its services are being managed.
- Oversee and assure the successful delivery of Provider Collaborative and Lead Provider Models, including the sub-contracts of the lead provider contract. In accordance with the business cases and agreements reached by the Board of Directors.
- Gain assurance that the Trust's action plans in relation to compliance and legislative frameworks, which are within the scope of the Committee, are robust, completed and signed off.
- Gain assurance that each contract is managed and that there are effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, financial, risk and assurance arrangements.
- On behalf of the Board of Directors provide assurance that the financial and quality risks associated with Provider Collaborative Contracts are articulated, evaluated and managed.
- Each Committee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
  - Review the management of the Corporate Risk Register and the Groups top risks;
  - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks;

- Report to the Board of Directors on any significant risk management and assurance issues.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

Deliverables

Assurance to the Board that:

- Effective systems and processes are in place to deliver the Trust's Financial Strategy and targets (including the Trust's capital resources) and that there is a clear understanding of current and emerging risk to that delivery.
- Effective systems are in place to deliver against the Trusts Green Plan.
- Effective systems and processes are in place to ensure the Trust's delivery against specific aspects of the Trust's Workforce Strategy/performance standards ensuring that the Trust has the workforce resources and capacity to deliver the Trust's Strategy and Operational Plans and that there is a clear understanding of current and emerging risk to that delivery.
- Effective systems and processes are in place to ensure that legislative, mandated (eg CQC, CQIN).
- Effective systems and processes are in place to manage commercial activity and business development, in line with the Trust's Strategy, Operational Plans, Trust policies and Monitor requirements, including major projects, business case development, tendering and post project evaluation arrangements and that there is a clear understanding of current and emerging risks.
- Effective systems and processes are in place for managing contractual relationships with Commissioners of services and that there is a clear understanding of current and emerging risks.
- Effective systems and processes are in place for the procurement of goods and services and that there is a clear understanding of current and emerging risks.
- That Estates and Information Technology infrastructure, DSPT systems and processes are designed, delivered and maintained to support the delivery of the Trust's Strategy and Operational Plans and that there is a clear understanding of current and emerging risks.
- The risks, that the Resource and Business Assurance Committee are responsible for, are appropriately identified and effective controls are in place and that strategic risk in relation to the effective and efficient resources, and the long term sustainability of the Trust and its services are being managed.
- The successful implementation and management of Provider Collaborative and Lead Provider models across the Trust.
- The Trust's action plans in relation to compliance and legislative frameworks are robust and completed/signed off, within the scope of this committee.
- The risks, that the Provider Collaborative and Lead Provider Committee are responsible for, are appropriately identified and effective controls are in place.

Sub Groups

PC Partnership Board (minutes to be received by committee)
PCLP Quality Group
PCLP Commission/Contracting Group
CEDAR Board (time-limited)

Quality and Performance Committee
Terms of Reference

Committee Name	Quality and Performance Committee (Q&P)
Committee Type	Standing committee of Board of Directors
Frequency	Eight times a year
Committee admin	Executive Assistant

Reporting Arrangements	Report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive
Deputy Chair	Non-Executive
Members	Chief Operating Officer Executive Director of Nursing, Therapies and Quality Assurance Executive Medical Director Other Non-Executive Directors
In Attendance	Director of Communications and Corporate Affairs as appropriate Associate Director of Involvement and Lived Experience Head of Performance Delivery Governor representatives x 2 Deputy Chief Operating Officer Deputy Director of Nursing and Quality Director of AHPs and Psychological Services Chief Pharmacist Deputy Director for Safer Care Director of Nursing, Mental Health, Learning Disabilities, Autism and Complex Care, NENC Integrated Care Board
Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies required for all members and those in attendance No deputies are permitted for Non-Executive Directors

Purpose
Provide assurance to the Board that: • The Trust has an effective system for clinical governance across the Trust. • The Trust has effective systems and processes in place for the management of risks pertaining to their area of focus, safety quality and performance across the Trust. • The Trust has an effective Assurance/Performance Framework. • The Trust complies with the law, best practice, governance and regulatory standards which are within the Committee's scope.

Authority
To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.
Deliverables
Assurance to the Board re: • The successful implementation of key quality and performance strategies, programmes of

work and systems.

- That national requirements and standards for patient safety and learning are effective.
- That there is an effective risk management system operating across the Trust including Group Risk Registers, a Corporate Risk Register and Board Assurance Framework which provides assurances to the Board that effective controls are in place to manage corporate risks.
- The Trust's action plans in relation to compliance and legislative frameworks are robust and completed/signed off, with the exception of areas covered by the Resource and Business Advisory Committee and Mental Health Legislation Committee.
- The implementation of NICE Guidance and other nationally agreed guidance as the basis for evidencing Clinical Effectiveness.
- The Trust's continued compliance with the CQC's Fundamental Standards.
- Compliance against the Coroners Amended Rules 2008.
- Standards of care, compliance with relevant standards and quality and risk arrangements.
- That information from patient and carer experience and involvement, including themes and trends, is informing service improvement.
- That information from staff experience, including themes and trends, is informing service improvement from a quality and safety perspective (in conjunction with the People Committee).
- The operation of all standing sub groups and delivery of any relevant reports/action plans in relation to current issues.
- Medicines safety, medicines quality, efficient use of medicines and clinical governance for the use of medicines.
- The management and use of Controlled Drugs within the Trust and across the local prescribing interface with the statutory Local Intelligence Network.
- The Committee has links to relevant service user/carer and Governor Forums.
- Effective systems and processes are in place with regard to clinical audits including robust processes to ensure recommendations are implemented and action plans are completed.
- The risks, that the Quality and Performance Committee are responsible for, are appropriately identified and effective controls are in place.
- Compliance with legal, regulatory and professional obligations, as well as good practice, relating to the handling of information, including compliance with the Freedom of Information Act 2000, UKGDPR/Data Protection Act 2018 and Data Protection and Security Toolkit.
- The Trust's open and just culture in relation to information governance (confidentiality, integrity and security breaches) and cyber incidents.
- The work of the Trust Caldicott Guardian, Data Protection Officer, Senior Information Risk Officer, Chief Clinical Information Officer, Chief Information Officer and Clinical Safety Officers in proactively and widely improving and promoting information governance and cyber security.
- Compliance with Health and Safety legislation.
- Compliance with emergency planning and resilience.

Sub Groups

Service User and Carer Reference Group
Medicines Optimisation Committee
Research Governance Oversight Group
Infection Prevention & Control Committee
Health, Safety & Security Group
Clinical Effectiveness Committee
Emergency Preparedness, Resilience & Response Group

Date of Committee Review: Jan 2025
Date of Board approval: April 2025
Date of previous Board approval: December 2023

Mental Health Legislation Committee
Terms of Reference

Committee Name	Mental Health Legislation Committee
Committee Type	Standing committee of Board of Directors
Frequency	Quarterly
Committee admin	Corporate Affairs Team

Reporting Arrangements	Minutes and report from Chair to Board of Directors Terms of reference to be reviewed annually by the Committee prior to approval by the Board of Directors
Membership	
Chair	Non-Executive Director
Deputy Chair	Non-Executive Director
Members	Executive Medical Director Executive Director of Nursing, Therapies and Quality Assurance Chief Operating Officer Executive Director of Workforce Other Non-Executive Directors Associate Director Information Governance and Mental Health Legislation Locality Group Medical Director representative Group Medical Director (Chair of the Mental Health Legislation Steering Group)
In Attendance	Director of Communications and Corporate Affairs Representatives of Mental Health Legislation Team Governor Representatives x 2
Quorum	A minimum of one Non-Executive Director (including the Chair) and a minimum of two Executive Directors
Deputies	Deputies required for all members and attendees Named deputies for Executive Directors will be accepted No deputies are permitted for Non-Executive Directors

Purpose

Provide assurance to the Board that:

- There are systems, structures and processes in place to ensure compliance with and to support the operation of Mental Health Legislation within inpatient and community settings, to ensure that any proposed changes to Mental Health Legislation are identified and monitored and necessary changes made to practice to comply and to ensure compliance with associated codes of practice and recognised best practice.
- The Trust has in place and uses appropriate policies and procedures in relation to Mental Health Legislation and to facilitate the publication and guidance of the legislation to all relevant staff, service users, carers and managers.
- Hospital Managers and appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health and associated legislation.
- The Committee will oversee and monitor the ongoing work in relation to Health Inequalities relating to the business of the Mental Health Legislation Committee.

Scope

- Ensure the formulation of Mental Health Act Legislation Steering Group and receive quarterly assurance reports on the Mental Health Legislation Steering Group's activities in relation to activities.
- Keep under review annually the Trusts "Delegation of Statutory Functions under the Mental Health Act 1983" policy including the Schedule of Delegation appended to that policy.
- Receive and review the Mental Health Legislation Activity and Monitoring Report (MHA Code of Practice requirements), this includes:
    - Emergency applications for detention (Section 4 & 5)
    - Emergency treatment (Section 62 & 64)
    - CTO recalls (Section 17E & Section 17F)

- Mental Health Tribunal referrals
- Receive assurance from the Mental Health Legislation Steering Group that the Trust is compliant with legislative frameworks and that there are robust processes in place to implement change as necessary in relation to Mental Health legislation and report on ongoing and new training needs.
- Receive the results in relation to the monitoring of policies linked to the Mental Health Act and Mental Capacity Act legislation and monitor any associated action plans.
- Consider and recommend the Annual Audit Plan in relation to Mental Health Legislation.
- Receive assurance that new law guidance and best practice is disseminated and actioned appropriately.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
  - Review the management of the Corporate Risk Register and the Groups top risks.
  - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks.
  - Report to the Board of Directors on any significant risk management and assurance issues.

Authority

To act on behalf of the Board to receive assurances that effective arrangements are in place with regard to those areas within the Committee's scope across the organisation.

Deliverables

Assurance to the Board re:

- The effective implementation of Mental Health Legislation within inpatient and community settings and compliance with associated Codes of Practice.
- The necessary policies and procedures in relation to mental health legislation are in place, updated and reviewed in line with legislative changes.
- The Trust's "Delegation of Statutory Functions under the Mental Health Act 1983" policy including the Schedule of Delegation appended to that policy, is reviewed annually.
- The Trust's compliance with requirements of the Mental Health Act and Mental Capacity Act Codes of Practice in respect of the mental health legislation and activity and monitoring reports.
- Compliance with and the effective implementation of Mental Health Legislation and that robust processes are in place to implement change as necessary in relation to Mental Health Legislation and reporting on ongoing and new training needs.
- Effective systems and processes are in place in respect of the monitoring of policies linked to the Mental Health Act and Mental Capacity Act legislation including robust processes to ensure recommendations and action plans are completed.
- Effective systems and processes are in place in respect of the dissemination and auctioning of new law guidance and best practice.
- The risks that the Mental Health Legislation Committee is responsible for are appropriately identified and effective controls are in place.
- Recommend the Annual Audit Plan in relation to Mental Health Legislation to the Audit Committee.
- The Committee will oversee and monitor the ongoing work in relation to Health Inequalities relating to the business of the Mental Health Legislation Committee.

Sub Groups

Mental Health Act Legislation Steering Group.
Any other task and finish subgroups associated with the business of the Committee.

Date of Committee review: February 2025
Date of Board approval: April 2025
Date of previous Board approval: December 2022

Board of Directors
Terms of Reference

Name	Board of Directors
Timing & Frequency	Board meetings will be held quarterly in public. Closed Board meetings will be held 8 times per year.
Admin support	Corporate Governance Manager/Deputy Trust Secretary
Reporting Arrangements	N/A

Membership	
Chair	Chair of the Board of Directors and Council of Governors
Vice Chair	Vice-Chair
Members	Chief Executive All other Non-Executive Directors All Executive Directors of the Board
In Attendance	Director of Corporate Affairs and Communications and Company Secretary ***NB:*** *Other Trust representatives may attend meetings of the Board by invitation.*
Quorum	Five members to include a minimum of two Executive Directors and a minimum of three Non-Executive Directors (including the Chair or Vice-Chair).
Deputies	The Trust Vice-Chair to deputise for Trust Chair. Deputies are permitted to attend for Executive Directors for discussion only. Deputies have no voting rights. No deputies are permitted for Non-Executive Directors.

Purpose

The Board of Directors is collectively responsible for the exercise of powers and the performance of the NHS Foundation Trust *(the Trust)* and for the effective discharge of the Board's statutory duties. The general duty of the Board and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for members of the Trust as a whole and for the public.

The Trust should be led by an effective and diverse board that is innovative and flexible. The Boards role is to promote the long-term sustainability of the Trust as part of the ICS and wider healthcare system in England, generating value for members, patients, service users and the public. The Board should give particular attention to the Trust's role in reducing health inequalities in access, experience, and outcomes.

The Board will establish the Trust's vision, values and strategy, ensuring alignment with the ICP's Integrated Care Strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. All Directors must act with integrity, lead by example, and promote the desired culture.

The Board should ensure that the necessary resources are in place for the Trust to meet its objectives, including its contribution to the objectives agreed by the ICB and its partners, and measure performance against them.

The Board should establish a framework of prudent and effective controls that enable risk to be assessed and managed.

For the Trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the Board should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.

The Board should ensure that workforce policies and practices are consistent with the Trust's values and support its long-term sustainability. The workforce should be able to raise any matters

of concern. The Board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

The Board should establish the Trust Constitution and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the Nolan principles.

The remainder of these Terms of Reference should be considered in the context of the principles of working within, and contributing to, the wider health and care system for the North East and North Cumbria.

Governance, rules and behaviours

Collective responsibility/decision making, arbitrated by the Chair i.e. all members of the Board have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact on the particular responsibilities of the Chief Executive Officer as the Accounting Officer. In addition, all directors must take decisions objectively and in the best interests of the Trust and avoid conflicts of interest.

As part of their role as members of a unitary Board, all directors have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk, mitigation, values, standards and strategy. In particular NEDS should scrutinise (i.e. assess and assure themselves of) the performance of the Executive Management Team in meeting agreed goals and objects, receive adequate information and monitor the reporting performance, satisfying themselves as to the integrity of financial, clinical and other information, and make sure the financial and clinical quality controls, and systems of risk management and governance are robust and implemented.

Compliance with the Trusts Constitution, Standing Orders and NHS Code of Governance will be maintained.

All members are expected to attend-absenteeism is an exception.

Scope

The Board of Directors is responsible for:

- Ensuring the quality and safety of healthcare services, education, training and research delivered by the Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, NHS Improvement/NHS England, the Care Quality Commission and other relevant NHS bodies.
- Setting the Trust's strategy, vision, values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders within the ICS and wider health and care system are understood, clearly communicated and met. In developing and articulating a clear vision for the Trust, it should be a formally agreed statement of the Trust's purpose and intended outcome which can be used as a basis for the Trust's overall strategy, planning and other decisions.
- Ensuring compliance by the Trust with its licence, its Constitution, statutory and regulatory requirements and contractual obligations.
- Setting the Trusts strategic aims taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and then periodically reviewing progress and management performance.
- Ensuring that the Trust exercises its functions effectively, efficiently and economically.

Authority

Decision making in line with the authority outlined in these Terms of Reference, the Trust Constitution, Standing Orders, Scheme of Reservation and Delegation and standing Financial Instructions.

Deliverables

Leadership

- Implementation and communication of a clear organisational vision, purpose and goals
- Implementation of strategies to position the organisation as an excellent employer
- Establishment of effective Board and Committee structures, both internal and external
- Establishment of good governance, clear lines of reporting and accountability

Culture, Ethics and Integrity

- Set, implement, communicate and embed the organisational values
- Promote a patient centred culture of openness, transparency, and candour
- Maintain high standards of corporate governance and personal integrity in the conduct of business
- Application of appropriate ethical standards
- Establish appeals panel as required by employment policies
- Adherence of directors, staff and people working for, but not employed by, the Trust (i.e., Council of Governors, volunteers) to codes of conduct

Strategy

- Set and ensure delivery of the Trust's strategic purpose, goals and objectives
- Ensure alignment of strategic plans to the wider ICS, ICB and ICP strategies and aims
- Monitor and review management performance to ensure objectives are met
- Oversee the delivery of planned services and achievement of objectives
- Develop, maintain, and ensure delivery of the Trust's Annual Business Plan, having due regard to the views of the Council of Governors
- Have regard to, and implement where necessary, national policies and strategies

Quality

- Responsibilities for ensuring internal controls are in place for clinical effectiveness, quality of care, patient safety and experience
- Intolerance of poor standards and foster a culture which puts the patients first
- Engage with stakeholders, including staff and service users, on quality issues and ensure appropriate escalation and dealing with issues
- Responsible for the publication of the Trust's Annual Quality Account
- The Board will take a holistic view of, and monitor, the ongoing work in relation to the delivery of work to address Health Inequalities

Finance

- Ensure the Trust operates effectively, efficiently, economically
- Ensure continuing financial viability, both at Trust and system level
- Ensure resources are properly managed and financial responsibilities are delivered
- Review performance identifying opportunities for improvement
- Responsible for the publication of the Trust's Annual Accounts

Governance and Compliance

- Ensuring comprehensive governance arrangements are in place by complying with principles, standards, and systems of corporate governance having regard to NHS statutory and regulatory requirements, codes of conduct, accountability and openness

- Ensure compliance with all requirements of the Trust's Provider Licence conditions
- Ensure compliance with the Trust's Constitution.
- Formulate, implement, and review the Trust's Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation
- Ensure compliance with the requirements of the NHS Act, Health and Social Care Act, Mental Health Act and other legislative requirements
- Required returns and disclosures made to the regulators
- Ensure effective systems are in place for the appropriate appointment and evaluation arrangements for senior positions
- Responsible for the publication of the Trust's Annual Report and Accounts

Risk Management

- Ensure an effective system of integrated governance, risk management and internal control across all clinical and corporate activities
- Determine and agree the Trust's Risk Appetite and review on a regular basis
- Develop, monitor, and review the Trusts Board Assurance Framework and Corporate Risk Register and manage the risks to the achievement of the Trusts strategic objectives
- Oversee and monitor the implementation of the Trusts Risk Management Strategy and Policy

Communication, Engagement and Involvement

- Develop and maintain effective communication channels between the Board, Trust Governors, Trust members, members of staff and the local community
- Develop and maintain effective communication channels with key stakeholders and partners
- Work in partnership with the Council of Governors and ensure they are equipped with skills and knowledge needed to undertake their role
- Ensure effective dissemination of Trust wide information on service developments, strategies, plans, good practice and learning lessons
- Ensure effective strategies, systems and processes are in place for staff, service users and carer and stakeholder involvement in development of care plans, review of quality of services and development of new services
- Ensure compliance with statutory and regulatory requirements associated for formal consultation requirements

Sub Groups

The following Committees will report to the Board via submission of minutes of meetings supported by verbal updates from the Chair:

- Audit Committee (statutory committee)
- Remuneration Committee (statutory committee)
- Mental Health Legislation Committee (statutory committee)
- Quality and Performance Committee
- Resource and Business Assurance Committee
- People Committee
- Charitable Funds Committee (committee of the Corporate Trustee)

Due to the confidential and sensitive nature of information concerning members of the Board of Directors, the Board shall receive a verbal summary of the Remuneration Committee meeting, where appropriate, rather than committee minutes.

Corporate Trustee
The Trust Board is regarded as having responsibility for exercising the functions of the Corporate Trustee. The Trust Board delegates these functions to the Charitable Funds Committee as a sub-committee of the Trust board, within any limits set out in the charitable funds section of Standing Financial Instructions and Scheme of Reservation and Delegation.

Current review date: April 2025

Date of previous Board approval: December 2023

Remuneration Committee
Terms of Reference

Committee Name:	Remuneration Committee
Committee Type:	Statutory Committee of the Trust Board
Timing & Frequency:	A minimum of one meeting to be held per year, however, meetings can be held more frequently as required by the Chair
Committee Secretary:	Director of Corporate Affairs and Communications
Reporting Arrangements:	Due to the confidential and sensitive nature of information concerning members of the Board of Directors, the Board shall receive a verbal summary of the committee meeting, if deemed

	appropriate (rather than committee minutes).

Membership	
Chair:	Chair of the Council of Governors and Board of Directors
Deputy Chair:	Vice-Chair
Members:	All Non-Executive Directors
In Attendance:	Chief Executive (advisory capacity only) Director of Corporate Affairs and Communications (advisory capacity only) Executive Director of Workforce and OD (advisory capacity only) ***NB:*** *The Chief Executive and other Executive Directors shall not be in attendance when their own remuneration, terms and conditions are discussed but may, at the discretion of the Committee attend to discuss the terms of other staff.*
Quorum:	Four members
Deputies:	The Vice-Chair to deputise for Chair but no deputies are permitted for Non-Executive Directors.

Purpose

To decide and review the remuneration, terms and conditions of office of the Foundation Trust's Executive Directors and comply with the requirements of NHS England's Code of Governance and any other statutory requirements.

To decide and review the remuneration, terms and conditions of office of the Trust Board Directors of the Trust's subsidiary companies.

Governance

- Meeting business can be agreed via email at the discretion of the Chair and to expedite decision making where appropriate.

Scope

To decide and review the remuneration, terms and conditions of office of the Foundation Trust's Executive Directors and comply with the requirements of NHS England's Code of Governance and any other statutory requirements.

To review the arrangements for local pay (Band 8C and above) in accordance with national arrangements for such members of staff where appropriate.

To decide and review the terms and conditions of office for the Board Directors of NTW Solutions.

Authority

Decision making in line with the delegated authority outlined in these terms of reference.

Deliverables

Decide upon, after taking appropriate advice and considering benchmarking data, appropriate remuneration and terms of service for the Chief Executive, Executive Directors employed by the Trust and Board Directors of the Trust's subsidiary companies including:

- All aspects of salary (including any performance related elements/bonuses),
- Provisions for other benefits including pensions and cars;
- Arrangements for termination of employment and other contractual terms.

In addition, the Remuneration Committee will review the arrangements for local pay (Band 8C and above) in accordance with national arrangements for such members of staff where appropriate.

Ensure that remuneration and terms of service of Executive Directors takes into account their individual contribution to the Trust, having proper regard to the Trusts circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of national guidance.

Receive a report on the outcomes of the appraisals for the Executive Directors from the Chief Executive.

Ensure compliance with NHS England's Code of Governance by taking the lead on behalf of the Board of Directors on:

- The Board of Directors shall not agree to a full time Executive Director taking one or more Non-Executive directorship of an NHS Foundation Trust or any other organisation of comparable size and complexity, nor the chairmanship of such an organisation.

- The Remuneration Committee should not agree to an Executive Director member of the Board leaving the employment of an NHS Foundation Trust, except in accordance with the Terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.

Ensure compliance with NHS England's Code of Governance relating to the appointment of Executive Directors and the appointment and removal of the Chief Executive.

- The Chairman and other Non-Executive Directors and (except in the case of the appointment of a Chief Executive) the Chief Executive, are responsible for deciding the appointment of Executive Directors, i.e. all Executive Directors should be appointed by a committee of the Chief Executive, Chairman and Non-Executive Directors.

- It is for the Non-Executive Directors (including the Chairman) to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.

- The roles of the Chairman and Chief Executive must not be undertaken by the same individual.

Ensure compliance with the requirements of "NHS Employers: Guidance for employers within the NHS on the process for making severance payments".

- Prior to receiving agreement to make a special severance payment from Monitor and before presenting a paper to the HM Treasury for approval, the Trust must follow the steps outlined in the guidance and be satisfied that termination of the employees employment, together with making a severance payment, is in the best interests of the employer and represents value for money. The Remuneration Committee should consider the proposal which should contain a Business Case for the severance payment.

- The Remuneration Committee's role is to:

    - Satisfy itself that it has the relevant information before it, to make a decision.
    - Conscientiously discuss and assess the merits of the case.

- Consider the payment or payment range being proposed and address whether it is appropriate taking into account the issues set out under initial considerations. The Committee should only approve such sum or range which it considers value for money, the best use of public funds and in the public interest.
- Keep a written record summarising its decision (remembering that such a document could potentially be subject to public scrutiny in various ways, for example by the Public Accounts Committee).
- Seek external advice, to be arranged via the Director of Communications and Corporate Affairs, where appropriate and as agreed by the Chair

Sub Groups

No Sub Groups

Links to other sub-committees/forums

Reports directly to the Board of Directors

Current review date: April 2025
Date of Board approval: April 2025
Date of previous review: December 2023

8. ANY OTHER BUSINESS / ITEMS FOR INFORMATION

Darren Best, Chair

8.1 CHAIR'S UPDATE

Darren Best, Chair

- Non-Executive Director appointment

REFERENCES

Only PDFs are attached

8.1 Chairs report April 2025 Final.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 8.1**
Date of meeting	Wednesday 30th April 2025		
Report title	Chairs Report		
Report Lead	Darren Best, Chair		
Prepared by	Kirsty Allan, Deputy Trust Secretary / Corporate Governance Manager		
Purpose	**For decision**	**For assurance**	**For awareness**
			x
Report previously considered by	N/A		
Executive summary	The Chair's report is a standing agenda item, for the purposes of transparency and accountability which provides the Board updates on strategic activity undertaken since the last meeting and draws the Board's attention to any other issues of significant interest. These include: - Staff Excellence Awards - Organisational Culture and Insightful Board Guidance - NHS 10-Year Health Plan - Raising the digital agenda - Trust Board of Directors - Fit and Proper Person Test		
Detail of corporate/ strategic risks	N/A		
Recommendation	N/A		
Supporting information / appendices	Appendix A – Insightful Board Guidance		

Meeting of the Board of Directors
Chair's Report
Wednesday 30th April 2025

Staff Excellence Awards 2025

CNTW is an extraordinary Trust, its outcomes made possible only through collective effort, dedication and most importantly, by our culture or working together in our teams to deliver excellent, specialist, personalised care to our service users and carers and outstanding support to each other. All of this was clear to see at our annual Staff Excellence Awards 2024, which was a fantastic celebration.

This year the awards ceremony will be held earlier in the year on Friday 27th June 2025 at Newcastle Civic Centre, so the awards don't coincide with the Trust's Annual Members' Meeting. We had a staggering number of nominations again this year and I would like to thank those for putting forward the amazing individuals and teams who you would like to be recognised. The standard of submissions was really high which means the judging process will be challenging. Finalists will be announced 4-6 weeks before the ceremony.

Organisational Culture

Culture is right at the heart of everything that matters to service users, carers, families and staff within CNTW and the NHS as a whole. This means putting great value on developing outstanding connections and relationships between individuals, teams and across organisations. It means a focus on values and behaviours, an emphasis on caring and compassionate, respectful, being honest and transparent and a constant quest to gain new perspectives.

NHS England has recently produced guidance to support boards to reflect and consider whether the leadership culture systems and processes that they have in play allow the board to get the right information and insights to lead the organisation safely. Appendix A outlines how the insightful board guidance aligns to our strategy 'With you in mind'. The board is going to be using some of its development time in the coming months to consider this guidance and how it compares with our current practices and what we can do to improve, as we are always seeking to improve. I will report back on this with any findings we make as a result in public over the course of the year and the start of that process has already begun by considering and changing the frequency and pattern of our Board meetings and Committees making the best use of the time we spend together for the benefit of the organisation.

Every year our Council of Governors and Board of Directors visit services throughout the organisation which is a great way to experience our culture by observing a strong emphasis on patient-centred care, compassion, professionalism, teamwork and commitment to quality, demonstrated through interactions where possible with service user experiences, with staff and getting to know us as a Board, the environment and overall approach to treatment, all underpinned by our values. Visits ensure that staff are actively involved in and informed about

the Trusts strategic goals and quality initiatives, while also providing a clear channel for feedback to the board from our frontline colleagues.

NHS 10-Year Health Plan
Since the Prime Minister and the Secretary of State for Health and Social Care launched Change NHS in October there has been a series of discussions with the public held in every region in England and a set of workshops with health and care staff across England. The 10-Year Health Plan sets out how to create a truly modern health service designed to meet the changing needs of our changing population. This will be focussed on the three shifts that the government, health service and experts agree need to happen. This includes moving care from hospitals to communities, making better use of technology and focussing on preventing sickness, not just treating it. All of these shifts the Trust is actively addressing ensuring people receive the right care, in the right place, at the right time. One of the initiatives I reported on in my December report is our new community service offering round-the-clock mental health support in the heart of Whitehaven. The Trust is also doing valuable work on the mental health crisis pathway, encouraging self-management of mental health issues and working alongside community programmes to get people the right support.

Raising the digital agenda
I am pleased to announce Jonathan Richardson has joined our Board of Director meetings from April 2025 as Digital Advisor to the Board to help with the digital strategy, which also links to one of the shifts - making better use of technology outlined above. Jonathan will be able to provide specialist expertise to help the board make decisions about digital agendas, influence the board thinking, help connect services to support integration and enable service transformation by improving patient care through digital means. By improving how we use technology across health and care will have a big impact on services in the future.

Trust Board of Directors
I would like to inform you of some upcoming changes to our Board of Directors.

Paula Breen joined the Board as Non-Executive Director in October 2019 and will be leaving the Trust at the end of March 2025. The Trust have started making plans for recruitment into this role. I would like to thank Paula for the contribution to the work of the Board of Directors and wider organisation which is both valued and appreciated and wish her well for the future.

The Council of Governors extended Michael Robinson, Non-Executive Directors terms of office to 30th September 2025 and we will seek to appoint to both posts over the coming months.

Kevin Scollay, Executive Director of Finance will be stepping down from his role following successful appointment as the new Chief Executive of North East Ambulance Service taking up this role in May. Kevin joined the Trust in 2022, and I would like to thank and congratulate Kevin for all he has undertaken for the Trust operating within an ever-changing and currently very challenging system with the huge pressure on public finance. The recruitment process for the Executive Director of Finance has commenced.

Fit and Proper Persons Test
A key responsibility in my role as Chair is to ensure that the Board of Directors are compliant with the Fit and Proper Persons Tests (FPPT). This regulation ensures that providers meet their obligations to only employ individuals who are fit for their role and to ensure that appropriate steps have been taken to ensure that they are of good character, are physically

and mentally fit, have the necessary qualifications, skills and experience for this role and can supply certain information including a Disclosure and Barring Service (DBS) check and full employment history, if required.

I will provide further assurance to the Council of Governors and Board of Directors when all appraisals and FPPT checks have been completed and checked in the coming months.

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 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 December 2024 – March 2025, I visited and / or met with:

- Service User Carer Reference Groups (December / February)
- Ferndene service visit
- Roselodge service visit
- Crisis Team, service visits to Lillyhall, Workington and Edenwood, Carleton Clinic
- HOPEs learning and feedback session
- Patient and Carer Involvement Experience - Sunderland
- Christmas Concert
- NHS 10-year workshop event
- Governors Induction
- Launch Trusts Veteran Strategy
- Community Care Group Directors

Local and Regional Network meetings

It is important to continually be connected 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.

Darren Best

Chair of the Council of Governors and Board of Directors
April 2025

Appendix A

Insightful Board Guidance

1. Introduction

This report summarises the key insights from the NHSE Insightful Board Guidance NHS England » The insightful provider board, published in November 2024. It outlines critical considerations for the Board for planning, handling, and seeking assurance. It provides practical recommendations for governance, leadership, and decision-making to support organisational improvement and system-wide collaboration. The insightful provider board guide builds on the Code of Governance for NHS provider trusts and discusses a range of governance and culture factors, meaningful information, and six key domains to ensure a comprehensive board framework for effective review, decision-making, and the development of strategy.

2. Key Responsibilities of the Board

The unitary board comprises Executive and Non-Executive Directors with equal responsibility and liability in exercising their duties and leading the Trust. The Board plays a pivotal role in:

- **Strategic Direction:** Setting challenging but achievable goals while anticipating the impact of policy, technological, and socioeconomic developments.
- **Quality and Compliance:** Ensuring statutory duties, regulatory requirements, and national priorities are met.
- **Value Creation:** Delivering safe, effective, and sustainable services that benefit both the Trust and the healthcare system.

The Board requires a diverse composition of knowledge, skills, and experience to reflect local populations and ensure constructive debate and decision-making. Clinical voices should be heard across all remits, and members must challenge one another constructively while fostering a culture of learning.

3. Effective Governance

Effective governance ensures timely, accurate information flow and enables rigorous decision-making through thematic analysis and the prompt escalation of key issues. "Active governance" involves reviewing the right information at the right time and ensuring issues are scrutinised by the appropriate people.

Board reports must be concise, highlighting key issues, risks, and mitigating actions. Benchmarking and triangulating data signals are essential to uncover underlying issues and inform better decisions.

4. Shaping Culture

The Board sets the "tone from the top" by role-modelling an open, transparent, and inclusive culture. The Board should embed a culture of quality improvement, innovation, and

transformational change to ensure productivity and efficiency, and help reduce variation in quality and performance of services to improve access and reduce health inequalities.

Board culture should be one of curiosity and appreciative inquiry, with provision of the right, accurate, and timely intelligence, and testing information against staff and patient reality. The board should consider NHS Providers guidance on problem-seeking boards, and distinguish between matters to address directly, and those on which to seek external independent review.

Key cultural principles include:

- **Openness and Transparency:** Fostering psychological safety and a just culture where staff and patients feel empowered to speak up.
- **Compassion & Inclusivity:** Listening to understand and promoting equality, diversity and inclusion while addressing behaviours inconsistent with NHS values.
- **Fair and Just:** Considering wider systemic issues, learning without fear of retribution, understanding why failings occurred and balancing learning and accountability.
- **Continuous Improvement:** Proactively seeking and applying lessons learned from local innovation and external best practices.
- **Problem-Sensing:** Detecting and addressing emerging issues early through multiple information sources.

5. Corporate Governance and Reporting Structures

Robust governance processes are essential for effective decision-making from ward to Board. Committees should focus on detailed scrutiny, enabling the Board to maintain a strategic focus. The committee structure must be reviewed annually to ensure it supports governance and organisational oversight effectively.

Non-Executive Directors provide an independent perspective on how information is scrutinised, and challenge key issues. It is recommended that each Non-Executive Director sit on more than one committee, to foster a diverse experience base and gain different perspectives.

The board committee structure must have a clear scheme of delegation, responsibilities, accountabilities, and standing financial instructions. This will ensure that committees themselves are effectively used for delegation, mitigate the risk of information overload, with more dedicated time for detailed scrutiny of particular issues, and escalation as required. Boards must be confident in the scope and robustness of committees, escalations, and reports arising, so should review the structure and effectiveness at least annually to ensure they remain fit for purpose and support board governance and organisational oversight. Committees should report regularly to the board in a balanced and insightful way, escalating key issues and risks, not simply repeating discussions.

6. Meaningful Information and Reporting

Board reports cover a range of issues including statutory requirements, strategy, quality, service delivery, use of resources, and internal, system and national priorities. Information must be relevant and insightful, focusing on outcomes and the impact of actions.

Reports should be concise and provide an initial review of appropriate metrics and commentary that should be considered by Board, to gain understanding of an issue or improve performance. They should not unnecessarily repeat background information, but focus on key messages, updates, and actions, to support discussions and provide assurance. The Board must be confident that information provided is a true reflection of the picture, and that no other considerations or issues are arising.

Senior leaders should provide insight into particular issues, with clear, logical, and consistent explanation of events, causes, and action taken, and professional views to complement information for greater insight. Information must be timely, valid, subject to review, fit for purpose, and allow for deep dives into particular issues. Data must be legible and accessible, with consistent time units for comparison, and forecasts where appropriate, such as in finance.

Boards and committees do not need to see every metric every month, and items should be escalated as required following scrutiny undertaken at the appropriate level. There must be a clear process for escalation within or outside of the normal reporting cycle, including review of ad-hoc information from third parties.

Board should prioritise outcomes over process updates and to assist in this, reports should:

- Be timely and contain concise information, focusing on key messages and action points
- Provide a balance of reassurance and assurance, with independent evidence when needed (fig 1), and
- Include exception reports to escalate critical issues outside standard reporting cycles.

Figure 1: lines for enquiry board members should be pursuing

6.1. Aggregation – integrated reporting

Integrated reports consolidate quality and performance data into a high-level overview, simplifying complex information and aiding strategic discussions by highlighting successes, risks, and trends. Reporting frameworks should align with strategic objectives, covering domains like quality, workforce, and finance, while allowing periodic insights. Boards should balance this with deep dives to uncover hidden issues and routinely analyse data for health inequalities, ethnicity, and deprivation to address gaps.

6.2. Triangulation and Analysis

Boards should triangulate data from various sources, including patient feedback, staff surveys, and national benchmarks, to identify emerging risks and unintended consequences. Charts can clarify trends and reduce unnecessary reactions to normal fluctuations. Statistical and analytical tools can be useful to guide decision-making, as discussed through the NHS England making data count programme, for effective triangulation of quantitative and qualitative data. Boards should also consider benchmarking against national data and targets for a broader understanding and further triangulation, to identify themes that are less evident from local data alone and focus improvement resource on wider patient outcomes.

7. Key Oversight Domains

The guidance outlines six domains for oversight and suggests information that the Board may consider for assurance, although notes that it is not the only or necessarily best way to frame such information, and not all should be routinely reported. Boards must thoughtfully consider the organisation's risks and priorities to develop a bespoke approach, using quality information for meaningful discussions that support learning and decision-making. A summary of guidance on each domain is detailed below.

Six domains for oversight:

1. Strategy: The Board must ensure its strategy 'With you in mind' delivers sustainable services, meets regulatory requirements, and aligns with national priorities, technological advances, and system objectives. Strategies should be developed in consultation with staff, partners, patients, and carers, set clear goals, track progress, and demonstrate success through collaboration.

2. Quality: The Board must monitor patient outcomes and safety and gain assurance on the quality of care provided and physical environment in which services are delivered. It must be mindful of its legal duty to involve the public in decision-making about services and ensure continuous quality improvement through a whole systems approach to collecting, analysing, using, and learning from feedback.

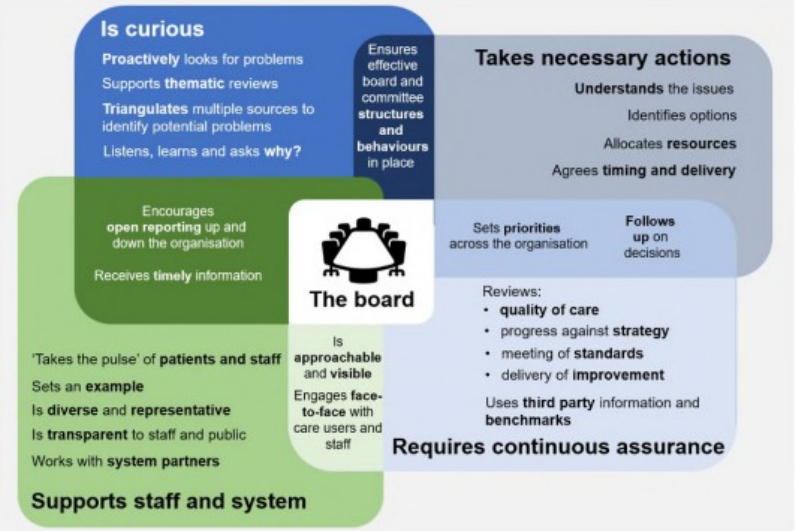
3. People: The Board must listen to and use staff feedback to inform strategic decisions. It must identify and address workforce inequalities, ensuring a safe and secure environment with health and wellbeing support in place, and foster workforce well-being and equity.

4. Access and Targets: The Board must ensure delivery against national commitments referring to the latest NHS England guidance and nationally assessed targets. It must ensure equitable access to services, paying particular attention to ethnicity and deprivation information to reduce health inequalities.

5. Productivity: The Board must ensure effective service delivery and asset use, improve productivity, and maintain care quality. Using national benchmarks, it should assess performance, guide resource planning, and support workforce growth, balancing efficiency with care standards.

6. Finance: The Board must maintain financial stability, aligned with system goals. There must be a balance between service improvements, investments, and efficiency, change plans, and the impact on workforce, quality, and financial sustainability, including for the wider health and care system.

Figure 2: the characteristics of effective NHS provider boards



8. Key Insights and considerations

When considering implementation of the guidance, there are a number of additional factors the Board should consider in context:

1. **Board Turnover:**
   Up and coming changes to board membership, creates both challenges and opportunities for leadership continuity, effective decision-making, and strategic direction alignment of operational resources to support discharging the duties and an opportunity to review the current designation of responsibilities for all aspects of quality.

2. **Governance Maturity:**
   The guidance emphasises the need for structured annual assessments of board and committee effectiveness; an external governance review has been commissioned, and the outcome is currently being reviewed.

3. **Shaping a Positive Culture:**
   The board's role in fostering an open, inclusive, and problem-sensing culture is critical following a period of prolonged instability. Strengthening engagement with frontline staff and patients to reinforce transparency and innovation should be prioritised.

4. **Data-Driven Oversight:**
   The emphasis on concise, meaningful reporting and triangulation of data is aligned with best practices. However, developing further capacity in tools such as Statistical Process Controls may enhance decision-making efficiency.

9. Independent Review of Governance and Well-Led

The Trust commissioned a review led by ConsultOne with the Board considering outcomes at the February Board meeting. The Board is planning a substantive board

session taking into consideration the insightful board guidance to further review systems of internal control, governance framework, leadership and culture over the coming months.

8.2 CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

- NENC ICB oversight meeting update
- EMG update

REFERENCES

Only PDFs are attached

8.2 CEO Report April 2025.pdf

Board of Directors – Closed meeting
Chief Executive's Report
Wednesday 30 April 2025

1. Trust updates

1.1. Health inequalities

Following the confirmation of our health inequalities governance structure at the December meeting of the Trust Board, the first meeting of our Health Equity Steering Group is scheduled for April. The group will oversee work across our five priority areas for tackling inequalities. A brief progress update is included below:

- Patient and Carer Race Equality Framework (PCREF) – current priorities include completing analysis of patient ethnicity data, the development of an anonymous patient and carer survey exploring experiences of discrimination and cultural competence in our services, and engagement of staff and partners through internal forums e.g. group EDI meetings and staff network, Everyturn PCREF Advisory Board.
- Children and Young People's Core20Plus5 – work against this priority will be integrated into existing transformation plans. Recent activity has focused on engagement with colleagues from the ICB's Healthier and Fairer programme, Child Health and Wellbeing Network and Mental Health, Learning Disabilities and Autism Transformation Programme to understand work ongoing system work linked to the CYPS access priority of the Core20Plus5 for Children and Young People.
- CNTW as an Anchor Institution – work is ongoing to develop our approach to Work and Health including our engagement with funded programmes across the system including NENC ICB Health and Growth Accelerator and the North of Tyne Combined Authority's Connect to Work programme.
- Digital Inclusion – current priorities include implementation of the Reasonable Adjustments Digital Flag and supporting the implementation of the NENC ICB Digital Inclusion Strategy including the roll-out of the region-wide device repurposing scheme. Further Trust-level plans to be developed.
- Morbidity and Mortality – conversations ongoing around the integration of work against this priority into existing Trust programmes with a further update to be shared at a future meeting.

The Board will receive regular reports on the work of the Group on an ongoing basis

1.2. Health Service Journal Digital Awards 2025 - Shortlist

The ePMA Project Team has been shortlisted in the Improving Medicines Management and Pharmacy through digital category for the Health Service Journal Digital Awards for 2025. The HSJ Digital Awards shines a light on teams and organisations driving meaningful change through technology, improving patient outcomes, streamlining processes, and enhancing the overall quality of care. Being shortlisted is a testament to the Trust's unwavering commitment to innovation and excellence in digital healthcare.

The ePMA Project Team, a collaboration between Digital and Pharmacy staff, successfully implemented ePMA across 57 Mental Health and Learning Disability wards at CNTW. As one of the first Mental Health Trusts to undertake this initiative, the project has significantly improved medicines safety, clinical workflow efficiency, and governance controls, aligning with our Digital Strategy. The integration of ePMA within the Trust EPR enhances prescribing accessibility, enables remote prescribing for geographically dispersed teams.

1.3 Executive Director of Finance

In March, it has been confirmed that Kevin Scollay, our Executive Director of Finance, has been appointed to the role of Chief Executive of the North East Ambulance Service NHS Foundation Trust (NEAS). Kevin has done a tremendous job for the Trust and we, and I, will miss him greatly. But he is going on to a bigger role at a very important time for NEAS and for the NHS and I'm sure everyone will join me in offering him congratulations and wishing him well.

We have commenced the recruitment process for the role I will announce more details in due course, and of course there will be plenty of time for people to catch up with Kev and wish him well and thank him personally before he leaves us. For now, let's just say well done.

2. National updates

2.1. NHS England

On 13 March 2025, Chief Executives across England attended an urgent NHS England meeting to discuss the challenging position across the NHS. On the same day, an announcement by Sir Kier Starmer was made confirming the decision to abolish NHS England and make it “fully integrated” into the Department of Health and Social Care. The timeline for these changes is yet to be determined.

There is a further ask to all Integrated Care Boards (ICBs) to reduce running and programme costs by 50%. It has also been confirmed that there will also be a reduction in all NHS management costs.

We have already been on this journey internally at CNTW for some time, but clearly, these national messages have no doubt caused a level of unrest both internally and externally to the NHS.

In the meantime, we are continuing to progress with our own annual and medium-term planning, and we remain in a strong position in that regard. We will work together to ensure that CNTW delivers and thrives as the NHS changes to meet the challenges that we all currently face.

2.2. Supreme Court Ruling

On Wednesday 16 April, Supreme Court judges ruled that the legal definition of a women is based on biological sex for the purpose of the Equality Act 2010. Whilst it is acknowledged that the ruling provides clarity, we are aware that it will have a significant emotional impact on people, and it is important that we take stock and consider the implications in a calm and

considered way. This will include a review of the impact on the NHS and its services however in the meantime, there will be no immediate impact for our people, and this will make no difference to our commitment to support the rights of trans people.

Here in CNTW, we are committed to our pledge of 'Give Respect, Get Respect', and ensuring an inclusive approach to our model of care and support, the support we give to our workforce, and enabling and defending the rights of all of our people and the people we serve.

2.3. Government's Spring Statement 2025

The Chancellor of the Exchequer, Rachel Reeves delivered the government's Spring Statement on Wednesday 26 March 2025. Some of the key policy announcements are as follows:

The Chancellor stated that the abolition of NHS England will ensure that money saved goes directly to improving services for patients. Ms Reeves recognised that the Health and Social Care Secretary is advancing crucial reforms to boost productivity and reduce expensive agency costs within the NHS, aiming to improve patient care.

The government will outline its spending plans and key public sector reforms at the Spending Review which will conclude on 11 June 2025. This review will detail day-to-day spending plans for the next four years, up to 2028-29, and capital spending plans for the next five years, up to 2029-30, alongside a 10-Year Infrastructure Strategy.

It was confirmed that the Resource Departmental Expenditure Limits (RDEL) envelope will grow at 1.2% in real terms per year from 2025-26 to 2029-30. Government departments will reduce their administrative budgets by 15% by the end of the decade. Savings on back-office functions will total at least £2.2 billion per year by the end of this period and ensure that front line services are prioritised.

The Office for Budget Responsibility (OBR) has now set out its final assessment of costings and confirmed that the welfare package announced by government will reduce welfare spending by £4.8 billion in 2029-30. It was also stated that one in eight young people are not in employment, training or education.

The statement is a reminder of the scale of the challenges facing our public services including the NHS. As part of this, it has never been more importance to reflect on our duties and responsibilities to ensure our money is well spent and our resources are used well.

The changes to universal credit and benefits have already been highlighted as a concern across health and care services, particularly for mental health providers, and this continues to be the case in light of the welfare reform in the context of increasing demand for services.

The chancellors speech can be found here

2.4. Nursing and Midwifery Council – Culture Transformation Plan 2025

Nursing and Midwifery Council – Culture Transformation Plan 2025

On the 20 March 2025, the NMC published their Culture Transformation Plan which is a 3-year programme to build a positive, empowering and inclusive culture for everyone involved in the regulatory process. The new culture will be underpinned by a strong anti-racist ethos and a commitment to improve the experience for the public and nursing and midwifery professionals.

The plan has been produced following the Independent Culture Review, by Nazir Afzal and Rise Associates, published last July. The report highlighted safeguarding concerns and found that people working in the organisation have experienced racism, discrimination and bullying.

The transformation of their culture is the first objective of the NMC's wider corporate plan for 2025-2026, which aims to win back trust and confidence in the ability to protect the public through the effective regulation of nurses, midwives and nursing associates. The other objectives are:

- Strengthening leadership at the organisation to drive change – a largely new executive team and a clear coaching approach will drive change by equipping our managers to be great leaders.
- Improving fitness to practise – acknowledging the need to improve at pace and resolve concerns as early as possible while not overburdening colleagues.
- Maintaining other core regulatory functions – focus on setting and evolving standards to meet the needs of today's workforce, while ensuring the standards remain fit for the future.
- Addressing our most significant challenges – managing risks including the financial position, integrity of the register, safeguarding and education quality assurance.

The NMC culture transformation plan is based on six pillars:

- Strong and effective leadership
- Values-based decision-making
- Embedding equality, diversity and inclusion (EDI)
- Ensuring psychological safety
- Enjoying work, and
- Regulatory fairness.

The plan will also lead to the rolling out of new strategies to promote race equity for registrants in the processes and race and gender equity for NMC colleagues.

Under plans for regulatory fairness, NMC want to ensure that our regulatory practices are timely, fair and effective. This includes:

- Starting work to modernise the Code and revalidation, with opportunities to input.
- Ensuring the fitness to practise process is compassionate, transparent and proportionate.
- Making sure timeliness of fitness to practise decision-making is enhanced.
- Bringing about greater parity of outcome between different ethnic groups.

- Delivering increased satisfaction with fitness to practise among stakeholders.
- Ensuring greater equity within the fitness to practise process.

The Plan can be found here.

2.5 The NHS Performance Assessment Framework 2025/26

As part of NHS England's work to set out changes to the NHS's operating model in 2024, they have developed an updated Assessment Framework which will replace the current Oversight Framework, setting out how success and areas for improvement will be identified, and how organisations will be rated. This will apply to Trusts who provide services, and to Integrated Care Boards (ICB) who have the responsibility to assess population need and arrange services to meet those needs. Additionally, NHS England has developed a Strategic Commissioning Framework to support ICBs strengthen their capability to drive the 3 shifts set out by the government.

The updated framework, to reflect the new government's mandate to the NHS and the 3 shifts as part of the Health Mission, builds on the one which was developed following engagement with organisations such as the Local Government Association, Healthwatch, Association of Directors of Children's Services, National Voices, Local Authority Chief Executives and think tanks and was subject to a public consultation in summer 2024. Extensive engagement with the NHS on the updated framework took place between December 2024 and January 2025.

The new Performance Assessment Framework is available here.

James Duncan
Chief Executive
April 2025

8.3 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

Date of next meeting
30 July 2025, St Nicholas Hospital Board Room and via MS Teams