Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

23 July 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 July 25 DRAFT (003).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: Wednesday 23 July 2025 Time: 10:00am – 12:30pm	
	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 30 April 2025	Darren Best, Chair	Enc 10.00am
1.4	Action Log and Matters Arising from previous meeting	Darren Best, Chair	Enc 10.05am
1.5	Integrated Performance Report (Quarter 1)	Ramona Duguid, Chief Operating Officer	Enc 10.05am
2. Strategic Ambition 1 – Quality care, every day			
2.1	Quality and Performance Committee Quarterly Assurance Report	Louise Nelson, Committee Chair	Enc 10.20am
2.2	Mental Health Legislation Committee Quarterly Assurance Report	Michael Robinson, Committee Chair	Enc 10.30am
2.3	Care Quality Commission final assessment reports - Community Services - Older People's Wards – high level feedback	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc 10.40am
	Break – 5 minutes		10.55am

3. Strategic Ambition 2 – Person led care, where and when it's needed			
3.1	Yewdale Ward - progress update report	Ramona Duguid, Chief Operating Officer	Enc 11.00am
4. Strategic Ambition 3 – a great place to work			
4.1	People Committee Quarterly Assurance Report	Brendan Hill, Committee Chair	Enc 11.10am
4.2	Equality, Diversity Inclusion Annual Report 2024/25	Lynne Shaw, Executive Director Workforce and OD	Enc 11.20am
4.3	Raising Concerns / Whistleblowing Report	Lynne Shaw, Executive Director Workforce and OD	Enc 11.30am
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 11.40am
5.2	Finance quarterly report (Quarter 1)	Chris Cressey, Interim Executive Director of Finance	Enc 11.50am
5.3	NHS 10 year plan	James Duncan, Chief Executive	Enc 12.00pm
6. Strategic Ambition 5 – working for, and with our communities			
6.1	No issues to report for the period		
7. Governance and Regulatory			
7.1	Audit Committee Assurance Report	Robin Earl, Audit Committee Chair	Enc 12.10pm
7.2	Trust Annual Plan 2025/26 (and Quality Priorities for 2025/26) - for approval	James Duncan, Chief Executive	Enc 12.15pm
7.3	Board Assurance Framework / Risk Management Report	Debbie Henderson, Director of Communications and Corporate Affairs	Enc 12.25pm
7.4	NTW Solutions Limited – Terms of Reference Review – for approval	Debbie Henderson, Director of Communications and Corporate Affairs	Enc 12.30pm

8. Any other business / items for information			
8.1	Chair's update	Darren Best, Chair	Enc
8.2	Chief Executive report	James Duncan, Chief Executive	Enc
8.3	Fit and Proper Persons Test annual update (for information only – presented to June closed Board due to national submission timeframes)	Debbie Henderson, Director of Communications and Corporate Affairs	Enc
8.4	Modern Slavery Statement 2025 (for information only – presented to June closed Board due to national submission timeframes)	Debbie Henderson, Director of Communications and Corporate Affairs	Enc
8.5	Questions from Governors and the public	Darren Best, Chair	
Date of next meeting Wednesday 5th November 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 30TH APRIL 2025

Darren Best, Chair

To Follow

REFERENCES

Only PDFs are attached

1.3 Board in public minutes DRAFT checked 30.04.2025.pdf

Minutes of the Board of Directors meeting held in Public
Wednesday 30th April 2025
Trust Board Room, St Nicholas Hospital and via Microsoft Teams

Present:
Darren Best, Chair
Brendan Hill, Non-Executive Director and Vice-Chair
Michael Robinson, Non-Executive Director and Senior Independent Director
Robin Earl, Non-Executive Director
Louise Nelson, Non-Executive Director
Rachel Bourne, Non-Executive Director
Vikas Kumar, Non-Executive Director

James Duncan, Chief Executive
Rajesh Nadkarni, Deputy Chief Executive / Medical Director
Ramona Duguid, Chief Operating Officer
Kevin Scollay, Executive Director of Finance
Lynne Shaw, Executive Director of Workforce and Organisational Development
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance
Jonathan Richardson, Digital Advisor to the Board of Directors

In attendance:
Debbie Henderson, Director of Corporate Affairs and Communications / Trust Secretary
Kirsty Allan, Corporate Governance Manager / Deputy Trust Secretary
Margaret Adams, Service User and Carers Reference Group Chair
Gemma Berry, Operations Manager, Network North - Care Quality Commission
Bob Cooper, Political Reporter, BBC Cumbria and BBC Politics North
Julie Lawlor, Associate Director, Partnerships and Improvement – North Care Group
One member of the public was in attendance
13 Governors was in attendance

STANDING AGENDA ITEMS

1.1 Welcome and apologies for absence

Darren Best welcomed everyone to the meeting which was live streamed via Microsoft Teams. Darren extended a warm welcome to Jonathan Richardson who has joined the Board of Director meetings as Digital Advisor to the Board of Directors providing expert guidance on digital strategy, innovation, supporting the board to make informed decisions and leverage technology to improve patient care and service delivery.

Darren informed Paula Breen, Non-Executive Director stood down from her role on 31st March 2025 and thanked 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.

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 at the end of May 2025. Darren thanked and congratulated Kevin for all he has undertaken for the Trust operating within an ever-changing and currently very challenging system with huge pressure on public finance. The recruitment process for Executive Director of Finance has commenced.

Darren explained that there were no questions submitted from members of the public but reminded if anyone does wish to submit questions these need to be in writing, aligned to the agenda and within three days prior to the meeting.

There were no apologies to note.

1.2 Confirmation of quoracy and Declarations of Interest

All Board members present and there were no declarations of interest to note.

1.3 Minutes of the meeting held 4 December 2024

Vikas Kumar advised being in attendance at the December meeting and requested for accuracy to be added to the attendee list on the minutes.

Approved: Subject to the amendment, the minutes of the meeting held 4 December 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 Integrated Performance Quarterly Report

Ramona Duguid referred to the report noting two additional items which includes how the monthly and quarterly reporting will be further developed for 2025/26 in line with the updated Board schedule and new national performance metrics which the Trust will be measured against for 2025/26.

Ramona explained that work is being carried out now on the draft metrics and the Trust draft performance against these. Measures will link directly to the NHS national oversight framework segmentation and will be reported quarterly to Board during 2025/26.

Ramona referred to highlights for Month 12 which are recorded in the report and explained a gradual improvement noted over the last 12 months from a performance perspective. She noted 5 areas of concern where recovery plans are in place. The areas for concern overseen by the Quality and Performance Committee are clinically ready for discharge, bed occupancy, the Trust approach to out of area placements which continues to see some pressure, continued focus around crisis support and neurodevelopmental waits for both children and young people and adults. The other area of concern, capacity recording, which was discussed at the last Mental Health Legislation Committee.

Sarah Rushbrooke drew the Boards attention to the significant reduction noted on mechanical restraint with the lowest reported position within the last two years and significant reduction in the use of prone restraint, which continues the trend seen over the last year.

James Duncan highlighted the continuous effort referring to prone restraint as two years ago the figure was 200 per month with the latest figure being 8 per month which shows a significant improvement. James referred to clinical supervision which has been a perennial performance issue which is now exceeding the performance level across the Trust and thanked everyone for their efforts ensuring clinical supervision takes place. James also referred to ‘A great place to work’ on clinical staff priority training with the Trust meeting 3 out of 9 standards and highlighted the level of performance across the Board which is reported within the report is significantly higher than previously reported, but this is not highlighted in the way this is reported currently in the performance report.

Darren Best referred to the positive assurance that training courses for staff are on target which is a good indicator around developing staff making sure they are undertaking the necessary training required. Clinical supervision was an area of concern with Non-Executive Director colleagues and to have this area exceeding the target is a significant improvement and highlighted the positive direction the Trust is taking with the ambition on Mechanical Restraint pushing towards reduction and replacement with more humane and effective approaches. The rise in neurodevelopmental pathway referrals particularly for children and young people remains a complex challenge being a national concern, with the Trust actively developing proposals to address this.

Darren Best referred to the ongoing challenge which remain in achieving timely and effective discharge for patients who are clinically ready for discharge due to various factors to find suitable placements that can have negative impacts on patients, hospitals and the broader healthcare system. Darren mentioned visiting Lotus Ward at Middlesbrough explaining the attitude and thinking of staff at

this unit is different and significant around reducing restrictive practice with no issues for patients in terms of being clinical ready for discharge. He cited this as an area of good practice that we should learn from.

The Board received the Integrated Performance Quarterly Report

2. STRATEGIC AMBITION 1 – QUALITY CARE, EVERYDAY

2.1 Quality and Performance Committee Report

Louise Nelson explained the Quality and Performance Committee plays a crucial role in holding the organisation accountable for improving health outcomes, reducing inequalities and enhancing productivity. She explained that a representative from the North East and North Cumbria Integrated Care Board (ICB) attends meetings of the Committee which helps ensure that these system-level goals are reflected in the committees work ensuring the ICBs perspective and priorities are actively considered in the monitoring and improvement of service quality.

The committee is currently managing four key risks on the Board Assurance Framework (BAF) which are interconnected with the Committee focussing on Patient Safety Incident Response Framework (PSIRF), reviewing violence and aggression, physical safety and all elements which make up the independent enquiries and receives and reviews all Patient Safety Incident Investigations (PSII).

Louise explained 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.

James Duncan mentioned 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. Sarah also mentioned Duncan Burton, Chief Nursing Officer for England is commencing a review of the nursing workforce and addressing variation in numbers between organisations.

Sarah Rushbrooke explained there is a national piece of work where all Chief Nurses have been asked to support reviewing safer staffing tools. CNTW use a Mental Health Optimisation Tool, which is the only key component of safer staffing in mental health, helping to determine the optimal number of staff needed on a ward based on patient acuity and dependency.

Darren Best mentioned a mental health and learning disability Trust like CNTW carries a lot of risk and the people who work for and with the Trust deal with a high level of risk every day and thanked the Quality and Performance Committee for managing those risks on behalf of the Board.

The Board received the Quality and Performance Committee report.

2.2 Mental Health Legislation Committee Report.

Michael Robinson explained the Committee receives assurances and systems, structures and processes to comply with the Mental Health Act and there are no Business Assurance Framework (BAF) risks assigned to the Committee however with the Mental Health Bill currently going through Parliament the Committee will monitor and consider adding to the BAF as a risk once the Bill is published.

Michael referred to the report and explained 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 actively invested in recruitment from ethnic minority communities remains ongoing with the next committee meeting reviewing appraisal proposals.

The committee reviewed care planning and implications with the feedback received from the CQC and the personalisation of care planning and reviewed a number of comments from the CQC relating to Mental Health Act Reviewer visits regarding estates and being fit for purpose.

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.

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. This will be subject to further consideration and scrutiny.

Rachael Bourne referred to the IPR report which outlines record of capacity / consent consistently off target with significant improvement across the Trust required and asked what the plan is to change this. Michael explained the work to improve record keeping of capacity and consent by implementing more robust systems for assessing and documenting patient's capacity, ensuring clear communication of information and utilising digital tools for consent processes which includes staff training, establishing clear policies and utilising electronic patient records to store relevant information securely.

Rajesh Nadkarni mentioned if the traction is not met this would be escalated to the Trust-wide Safety Group (TSG) for further review and action.

The Board received the Mental Health Legislation Committee Report.

2.3 Care Quality Commission – Learning Disabilities and Autism Services Report
Sarah Rushbrooke referred to the report explaining the CQC undertook a series of unannounced visits to learning disability and autism wards in July and September 2024 where three wards were visited; Mitford Unit, Roselodge and Edenwood. Sarah provided assurance since the inspection the Trust has been working closely with the CQC on areas for improvement which have been noted through the IPR report which highlighted restrictive practice, reduction of violence and aggression for patients and staff and despite the inspection being some time ago the Trust has continued to undertake the improvements prior to receiving the final report due to be published on 8th May 2025. Sarah confirmed the report once published will be provided to the next Public Board in July.

2.4 Trust learning from the Independent Mental Health Homicide Report into the treatment of Valdo Calocane

Rajesh Nadkarni reported that NHS England has published its independent mental health homicide report into the treatment of Valdo Calocane by Nottinghamshire Health Care NHS Foundation Trust and explained NHS England required provider organisations and the system to learn from the incident to improve intensive and assertive community treatment for people with serious mental illness. Rajesh explained the Trust-wide Safety Group (TSG) has oversight of coordinating and managing actions 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 incorporates 10 recommendations from all reports into Valdo Calocane's care and is included in the papers of the Board for information.

Rajesh explained further through presentation that the Trust has reviewed all the findings from the independent report and presented the 10 actions which the Trust will embed into quality governance arrangements which will be reported to the Quality and Performance Committee.

Louise Nelson mentioned for individuals struggling to engage with mental health services, care planning acts as a "golden thread" providing structured and consistent framework for those supporting

their needs. Louise also mentioned making carer impact a mandatory training principle which will aim to ensure all staff understand the crucial role carers play in supporting patients and their care, fostering a more person-centred and holistic approach to healthcare delivery.

Lynne Shaw explained that, following the Executive Management Group meeting, agreement was made for carer awareness training to be one of the priority training areas.

James Duncan explained the ongoing work will be embedded within the model of care to ensure that those that have significant needs are channelled with the right level of support as quickly as possible He emphasised that the Trust has identified cohort of individuals within the trusts services that need that support.

Darren thanked the Trustwide Safety Group and others involved reviewing NHS England's homicide report and scrutinising the implications from a CNTW perspective.

Rajesh mentioned there is a need to have a robust risk assessment process of identifying, analysing and evaluating potential risks and developing strategies to mitigate or manage them effectively. It is also critical to have robust multi-agency working with local authorities and police.

Further work is required on sharing of information with partners which the Trust is currently reviewing and Rajesh explained sharing of information is crucial for effective care but must be done responsibly and ethically, adhering to legal and professional guidelines.

Jonathan Richardson referred to information sharing and gave assurance that regionally and within the Trust the use of the Great North Care Record is established and growing. This is a portal that professionals access and share information with appropriate consent. The Trust are looking to share the new risk assessment on the portal which will provide the most up to date comprehensive individual approach to risks and management.

Sarah Rushbrooke mentioned work is ongoing within the Lived Experience Service identifying gaps particularly impacting culturally diverse individuals to improve delivery of care for diverse backgrounds.

The Board received the Trust learning from the Independent Mental Health Homicide Report into the treatment of Valdo Calocane

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

3.1 West Cumbria Strategic Case for Change – for approval

Darren Best referred to a letter received from Mr Josh McAlister, MP for Whitehaven and Workington addressed to all members of the Board regarding the proposed closure of Yewdale ward in West Cumbria. Darren welcomed the letter from Mr McAlister making a case for his community and bringing those concerns to the Boards attention.

Darren referred to the report highlighting a link to the outcome of the engagement activity the Trust undertook in relation to Yewdale in West Cumbria and thanked the Executive Team and Communication Team for the comprehensive nature of the engagement activity undertaken. Darren also advised that the ICB are aligned with the proposal set out within the report.

Darren provided a brief overview of the reasoning for the engagement for Yewdale highlighting six main areas which are: the only mix-sex acute admission ward within the Trust; isolated nature of the ward; difficulties relating to recruitment and retention of staff; medical cover being problematic, the building not being fit for purpose and the overall operational delivery around performance which are all important reasons why the Trust has made necessary steps to undertake a comprehensive engagement activity.

James Duncan mentioned the issues at Yewdale are longstanding and well known which are articulated within the report. The board have considered the development of the proposal on several occasions with the board sanctioning a period of comprehensive public engagement from October 2024 with full details set out within the report. James also confirmed the period of engagement also included discussions with Cumberland Overview and Scrutiny Committee on key areas in relation to impact on local access, how these changes fit with national policy direction and the improvement in outcomes which are required for the local population. The Trust have also met with Councillors in West Cumbria and the local Member of Parliament, Mr Josh McAlister who specifically requested feedback. James explained the scrutiny and engagement is welcomed

The report sets out the reprovision of the service in terms of acute adult inpatients is taking place alongside one of the most radical changes in community services, as part of a national pilot. James explained 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 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.

James explained that those people who do need acute inpatient admission are those that are most acutely unwell who require the right care, the right staff and the right support giving the best therapeutic intervention possible.

James referred to decision making which is the Boards responsibility to ensure the Trust is providing safe, effective services, being accountable for delivering of those services and therefore the decision lies with the Board to make that decision around the reprovision of Yewdale. The Integrated Care Board (ICB) has a critical role with oversight and management of the system ensuring the Trust is conforming with due process regarding public consultation. The ICB have met with the Overview and Scrutiny Committee and have also reviewed the public engagement which has been undertaken on the proposal set out in the report. They have agreed that further public consultation is not required on this strategic case for change and agreed with the proposals for change.

James mentioned pending the decision to re-provide beds from Yewdale to Carleton Clinic in Carlisle then agreement needs to be made alongside the ICB regarding the process of transition with the main priority being the safety and quality of those services and the transitions for individual patients being managed well.

Ramona referred to the tremendous work the staff have provided over the last three months whilst undertaken the level of engagement, continuing to deliver and maintain fantastic care in difficult and challenging circumstances. Ramona explained the Trust is continuing to work with staff to ensure they are supported throughout the process with the aim to ensure retention of the valuable clinical skills and experience from support and registered staff to minimise any employment impacts within Whitehaven.

Michael Robinson referred to the caveats within the report. James Duncan ashes the board to confirm that the four caveats which are articulated within the report have the full Boards commitment to comply, consider and work with the ICB and partner organisations. The Board agreed that was the case.

Following the discussions which were fundamentally around quality and safety that Yewdale cannot continue it its current form, formal agreement was provided from the Board to the reprovision of beds currently at Yewdale to move to the Carleton Clinic in Carlisle which is a fully functioning mental health hospital site.

The Board received the West Cumbria Strategic Case for Change
ACTION: Agreement was reached of the reprovision of services from Yewdale unit to Carleton Clinic and for Yewdale to permanently close.

4. STRAEGIC AMBITION 3 – A GREAT PLACE TO WORK

4.1 People Committee Report

Brendan Hill and Lynne Shaw referred to the report and highlighted the work being undertaken around improving metrics around staff training. 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.

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. 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.

Lynne Shaw mentioned that 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 Board received the People Committee Report.

4.2 Staff survey outcome (including actions / areas of focus for 2025)

Lynne Shaw explained that the survey results provide valuable insights into staff experiences which will be used to inform improvements in working conditions and ultimately patient care. The survey shows mixed outcomes with some areas showing positive trends and others needing further attention.

CNTW response rate to the survey was 42% which is an increase of 1% on last year but is very disappointing. The Trust undertook a mixed mode of delivery this year which was applied within inpatient services receiving a paper copy of the survey and non-inpatient receiving an online version. This resulted in no difference to the outcome measures therefore the method receiving the survey will be considered for next year.

Lynne mentioned that there are many positive areas of note in this year's Staff Survey with pleasing progress made in staff satisfaction, with measures on workplace experience generally reported at higher levels than 2023. This includes measures relating to flexible working and respect and civility among teams. Lynne noted though that the level reporting they feel safe to speak up has declined as well as those feeling that immediate managers values their work and feeling valued by their wider team. Although there is some improvement in relation to experiences of workload and staffing pressure the overall scores remain a concern.

Lynne explained in 2024, the NHS focused on strengthening sexual safety protections for staff and service users through legislation and initiatives which includes training, risk assessments and promoting a culture where unwanted sexual behaviour is not tolerated. The Trust relaunched the Give Respect Get Respect campaign with a bulling survey which was reviewed in detail at the People Committee and Trust Leadership Forum as well as appointing four Freedom to Speak Up Guardians which over all four of the Trusts locality areas. The Trust is also developing a new violence and aggression risk assessment. Many areas highlighted throughout the Staff Survey are key elements of the Leadership Development Programme which is due to be launched soon.

Robin Earl asked if there are any familiar hotspots geographically or team wise across the organisation. Lynne mentioned that data is available for all CBUs and teams and this has been distributed across the Trust management structure, noting areas of concern. Lynne referred to medical staff reporting positive outcomes which reflects confidence in treatment quality and improvements in morale and engagement which ultimately contribute to better patient care.

James Duncan mentioned the most important information at the team level which help identify specific team-related issues, such as communication problems, low morale or lack of collaboration allowing for targeted interventions and improvements to be made and explained this feedback is crucial for fostering a more positive and productive team environment. Following the survey the Trust will focus on working with team leaders to address specific issues and improve staff engagement which will include listening to staff, co-creating solutions and providing resources and support for leaders to better engage with their teams with the Trust investing in a leadership development programme to provide team leaders with the skills and resources they need to support their teams which includes training on effective communications, conflict resolution and creating a supportive work environment with the first sessions of the programme being very positive.

Michael Robinson mentioned in response to communications to staff how does the Trust link responses to the survey to trust actions so people completing the survey can understand the impact. Lynne Shaw mentioned information is regularly circulated through the Trust Bulletin which is related back to key areas of the survey. Lynne highlighted two longstanding key areas why staff don't complete the survey is the perception that their feedback won't be acted upon and concerns about anonymity.

Vikas Kumar mentioned staff on short-term visa's may feel less confident in completing the staff survey due to concerns about potential repercussions related to their visa status and even with assurances of anonymity some staff may be hesitant to fully participate if they believe their responses could be linked back to them, potentially impacting their work environment or visa status. Vikas also mentioned staff on visa may not fully understand the purpose and implications of the survey leading to hesitancy or reluctance to participate as they may have difficulty understanding the survey questions or expressing their view accurately.

Ramona Duguid referred to low survey completion rates especially with frequent surveys are a common concern referring to NHS survey but also the quarterly pulse survey being a national mandated survey and doing those together needs to be pitched at the right level also recognising during September – November 2024 was a challenging period relating to a specific pathway with high level of CQC focus and the level of change within the organisation at various levels coupled with the medium term financial plan.

Debbie Henderson mentioned information flow from the Communications Team can only go so far within the Trust with the need to address how information reaches ground-floor level to effectively support line managers in communicating trust messages to ground floor staff with a focus on equipping them with tools, training and supportive environment which includes clear communication protocols, regular updates and opportunities to feedback from a communications perspective.

Darren Best referred to the staff survey being important and a priority area of the Trust and with the latest survey completion rate of 42% compared to the national average of 50% is a concern which could indicate that the survey is not reaching or engaging all staff or that staff are disengaged or hesitant to participate highlighting this to be a leadership failure particularly in fostering an environment of trust and transparency with leadership needing to create an open culture of communication where staff feel comfortable raising concerns and expressing their views feeling safe and valued.

The Board received Staff survey outcome (including actions / areas of focus for 2025)

4.3 Equality, Diversity and Inclusion Board Objectives 2025/26
Lynne Shaw explained in June 2023, NHS England published the first NHS Equality, Diversity and Inclusion (EDI) Improvement Plan which centres around six high impact areas which all board

members have individual and collective objectives linked to EDI outlined in Appendix 1 of the report. A to C of the objectives were co-produced with the Staff Networks. Lynne explained the Veterans Network did not have an objective for Board members but requested support with recruitment which is not a strategic objective and will be picked up separately by Lynne. The remainder of the objectives D to J outline which Board members are aligned and will be assessed and measured against as part of their annual appraisal.

Darren Best mentioned it is important to review progress against the objectives and adopt a mid-year review with external scrutiny and accountability and suggested to use the Network Chairs meeting as the group who will hold the Board to account for the performance of the Board.

The Board approved the EDI objectives to be included in all Board member appraisals for the next financial year.

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

5.1 Resource and Business Assurance Committee Report
Brendan Hill referred to the report and explained the committee receives assurance on the implementation and delivery of finance, estates, digital, sustainability and provider collaborative. There are currently 3 risks aligned to the committee.
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 Committee recognised that the backlog position was challenging with estates and capital issues being reflected in Mental Health Reviewer visits during the period.

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. 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.

In relation to CARE, Environment, Development and Re-provision (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.

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.

Jonathan Richardson mentioned from a patient, carer, professional and provider perspective is broad and having a separate digital committee would be welcomed. Darren also mentioned the additional work placed on RBAC with digital and provider collaborative being placed in this committee would help the workload between committees if there was a separate digital committee to provide the right focus it requires.

Darren Best referred to the work undertaken at Bamburgh and also referred to the Hadrian Clinic at Centre of Ageing and Vitality (CAV) former General Hospital site suggested for an update to be provided at a future board session on the planned moved with timescales.

Ramona Duguid mentioned from an operational delivery perspective all adult services will be moved or in the process of being moved by the next RBAC meeting in July 2025 with young persons services being move a few months later. It was agreed for a high-level briefing to be prepared for board members.

The Board received the Resource and Business Assurance Committee Report.

ACTION: A high-level briefing to be provided to board members on estate update.

5.2 Finance quarterly report (Quarter 4)
Kevin Scollay referred to the report and informed the Trust has ended the financial year in a good financial position ahead of plan which helps move into 2025/26 which has allowed more flexibility around the Capital Department Expenditure Limit (CDEL) however challenge does remain for the current year.

Rachel Bourne give recognition to the hard work and determination of staff which shows the achievement to date ending the financial year in a good position.

James Duncan mentioned the Trust is seen as an organisation which delivers and have delivered against the plan but to do this needed to receive additional support from the system who has trust in the organisation therefore the Trust has come from a small deficit to a surplus position.

The Board received the Finance quarterly report (Quarter 4)

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

6.1 Live Experience Service update
Sarah Rushbrooke referred to the six-monthly update report. Sarah gave recognition to Margaret Adams, Chair of the Service User and Carer Reference Group (SURG) who has undertaken a phenomenal role as Chair over the years and to support Margaret two co-chairs and a deputy chair have been appointed to provide valuable support and leadership for this group as there has been an increase in attendance at the SURG in recent months.

The report reflects on the benchmarking exercise undertaken to review engagement, forums and support groups across the organisation and Sarah highlighted the challenge where there are gaps in the peer supporter offer with culturally diverse backgrounds which is an area of focus over the coming year. There has been greater involvement at local level in terms of service user and carer forums and triangle of care groups at local care group level with much more leadership. There is a focus on carer support and awareness training to be a priority for the organisation with a dashboard system for Triangle of Care performance analysis recommended and to be embedded to support the accurate reporting of operational service performance.

Rachel Bourne mentioned it is helpful to see the breadth of involvement throughout the Trust which is very broad but ask for confirmation on the depth of the work undertaken and what level is the involvement at. Sarah explained the first part of the exercise was to understand what work is currently ongoing throughout the Trust and the next step is to review what does involvement look like with a focus on engaging directly with service users and carers using various methods to gather their experiences and perspectives to ensure their voices are heard and considered in decision-making processes. Sarah advised this work will be updated within the next report which will be submitted to Quality and Performance Committee.

Vikas Kumar referred to the strategic objectives of the charity SHINE to align those with culturally diverse service users, focus on understanding the needs and experiences of different communities, fostering partnerships and ensuring that all services are accessible and inclusive and addressing barriers to access, ensuring that all relevant groups can participate.

Ramona Duguid referred to the recruitment of the co-chairs and deputy chairs being a positive step in growing leadership in this area. Ramona referred to 5.1 of the report and suggested rephasing this section to have peer support resource in the right place across the new model of care ensuring they are accessible, relevant and integrated with other support systems. Sarah Rushbrooke agreed that peer support resource need to be aligned to where the need is with work ongoing.

Darren Best mentioned this is the correct report for peer support which is a key component of lived experiences reporting, enriching the content and impact of these reports as peer support plays a vital

role emphasises the power of shared experiences and the benefits of mutual learning and empowerment, leading to more person-centred and effective care.

The Board received an update on the Live Experience Service update

6.2 Charitable Funds Committee update
Vikas Kumar provided background to the Charity Committee which plays a vital role in managing and allocating charitable funds to support various aspects of services within the organisation and is responsible for ensuring that donations or investments are used effectively to enhanced patient care and staff wellbeing. The Charity Committee is aligned with the requirements set by the Charity Commission. The committee reviews proposals to spend charitable funds ensuring that they are in line with the charity's purpose and objectives.

There are currently 51 specific funds and one general fund which is the SHINE fund. There have been 11 applications to withdraw from the specific funds and 8 from the SHINE fund between January and April 2025.

The Committee is currently reviewing their long-term strategy and through a development day in January valuable work was undertaken reviewing and setting the Committees objectives embedding Equality, Diversity and Inclusion (EDI) being central to the work the committee undertakes, bring service user and carer voices closer to the Charity's work as well as working closely with the Staff Networks.

The SHINE fund is currently developing their Corporate Partners Guide to have a clear understanding of roles and goals, share common values and communicate effectively to build strong partnerships, define desired impact, leverage unique assets and collaborate on strategy to achieve shared objectives with this piece of work currently in draft form.

Vikas explained the roles of marketing and fundraising officers have now been secured and explained the fundraising officer joined the communications team as an apprentice transitioning to a full-time position which signifies not only completion of the apprenticeship programme but their valuable contributions to the organisation which allows them to continue their career progression and further develop their skills bringing valuable insights into the charity's work.

The Board received the Charitable Funds Committee update

7. GOVERNANCE AND REGULATORY

7.1 Audit Committee Assurance Report
Robin Earl explained the main role of the Audit Committee is to provide assurance regarding the effectiveness of the organisations governance, risk management and internal control systems with the actual members of the committee being Non-Executive Directors who play a crucial role in providing independent scrutiny of executive performance, ensuring transparency and accountability within the organisation.

During 2025, there have been three meetings take place with one being to review the accounts for the Charity. The committee works on a group audit basis considering activities for the subsidiary company of the Trust. The committee reviewed the Board Assurance Framework (BAF) which the committee has delegated responsibility to comment on the adequacy and effectiveness and Robin was pleased to announce internal auditors have scrutinised the framework and have confirmed substantial assurance as well as receiving an internal audit report on the wider risk management processes in the Trust also receiving substantial assurance.

Specific items for decision Robin mentioned the proposal to reduce risk score 2548 on the BAF which relates to partnership working and having accessed evidence and assurances around relationships that the Trust is working with key partners the likelihood score currently 3 should be downgraded to 2. Robin asked the board to support time at a future develop session to review risk appetite.

February committee the committee reviewed the Standing Financial Instructions and Scheme of Delegation of the Trust and also had considerable input from the Digital Team reviewing risks around digital infrastructure and noted high level of assurance and best practice in response to work around digital environments and wireless network security.

Oversight of declaration of interests and standards of business conduct was presented and with the policy recently updated a further updated will be provided later in the year to make sure changes to the policy are having the required impact and the Committee reviewed the Terms of Reference ensuring it is aligned with national good practice. Robin explained an annual effectiveness review of the committee was undertaken and was pleased to report the committee is functioning properly and meeting is objectives.

The Board received the Audit Committee Report.

7.2 Trust Annual Plan 2025/26 (and Quality Priorities for 2025/26) – for approval

James Duncan referred to the report which provides an overview of the annual plan for 2025/26 for ratification and to provided a summary of the processes 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.

The Trust has submitted its 2025/26 operational plan to the ICB in March which included plans for finance, productivity, workforce and performance and activity. A set of Trust priorities for 2025.26 have been developed based on the organisational strategy 'With you in Mind' considering local and national priorities. 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 the Trust Model of Care and support which is outlined in Appendix 1 of the report.

James explained the Board will receive assurance through a summary of key monthly reported areas by exception, alongside progress with the Trust plan including priorities set out against the five strategic ambitions and will be working with Committees to ensure clarity what is needed measures and deliverables and how they will be reported.

The Board received the Trust Annual Plan 2025/26 (and Quality Priorities for 2025/26)

7.3 Board Assurance Framework / Risk Management Report
Debbie Henderson referred to the report which the main points picked up within Committees assurance reporting.

James Duncan referred to the report and the work undertaken providing clear written Board Assurance Framework to effectively manage strategic risks ensuring they are achieving the strategic objectives providing a structured approach to identifying and mapping of sources of assurance, coordinating different assurance activities and providing the board with a comprehensive overview of the organisation's performance and expressed thanks to the team on the outstanding work on the Board Assurance Framework, the dedication and expertise has been instrumental in developing such a comprehensive and effective framework.

7.4 Board Committee Terms of Reference
Debbie Henderson referred to the report and explained all Board Committees are subject to an annual review and a summary of changes are detailed within the report. Debbie mentioned except for the Audit Committee, all Board Committees have included a section to oversee and monitor the ongoing work in relation to Health Inequalities relating to the business of each Committee as well as the Board of Directors Terms of Reference.

The Board received the Board Committee Terms of Reference

8. Any Other Business

8.1 Chairs update
Darren Best referred to the report for information.

8.2 Chief Executive Report
James Duncan referred to the report for information and thanked Kevin Scollay for his hard work as Executive Director of Finance who will be leaving the Trust at the end of May taking up a new role as Chief Executive Officer for the North East Ambulance Service.

8.3 Questions from Governors and the public
None to note

Date and time of next meeting
Wednesday 30 July 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 September 2025.pdf

Board of Directors Meeting held in public

Action Log as at 24 September 2025

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					
30.04.25 (2.3)	CQC report	CQC final assessment reports	Sarah Rushbrooke	July 2025	Items added to July agenda.
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	~~July 2025~~ November 2025	Deferred from July.
30.04.25 (5.1)	Resource and Business Assurance Committee report	Update on progress against the capital programme / Estate developments to be provided to a future Board meeting.	Chris Cressey	TBC	Update or briefing – to be confirmed
Completed Actions					
		No completed actions to note			

1.5 INTEGRATED PERFORMANCE QUARTERLY REPORT (QUARTER 1)

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

1.5a Board front sheet - IPR - July 2025 Meeting.pdf

1.5b Trust IPR Report - May 2025 - Board FINAL.pdf

Meeting	**Board of Directors**		**Agenda item: 1.5**
Date of meeting	**Wednesday 23rd July 2025**		
Report title	**Integrated Performance Report (IPR) Period: May 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 summary	**Positive highlights for May-25** • **Do you feel safe? –** Reported consistently above target for 12 months. • **Clinical Supervision** – Reported at 81.9% as at 30/04/25 above the 80% target • **MRE Restraints** – Lowest position reported for 24 months • **Prone Restraints –** Decreased in the month and remains below lower control limit for 9th consecutive month. • **Psychiatric Liaison seen within ED within 1 hour –** Reported above the internal target (80.0%) at 84.9%. • **Psychiatric Liaison seen within Ward in 24 hours –** Continues to be reported above target • **Active Inappropriate Out of Area Placements –** There were no reported active inappropriate placements as at 31/05/2025. **Areas of concern and where recovery plans are in place** • Clinically Ready for Discharge & bed occupancy. • Crisis Very Urgent (4 hours) • Neurodevelopmental waits for children and young people and adults. • % waiting < 4 weeks to treatment – Adult & Older Adult Services • Sickness and Appraisal rates		
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

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2025-26 Month 2 (May 2025)

With YOU in mind

Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts.

	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	**Normal Variation** Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	**Concern** Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	**Improvement** Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	**Achieve at random** This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	**Consistently off target** This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	**Consistently achieve** This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Interpreting SPC charts

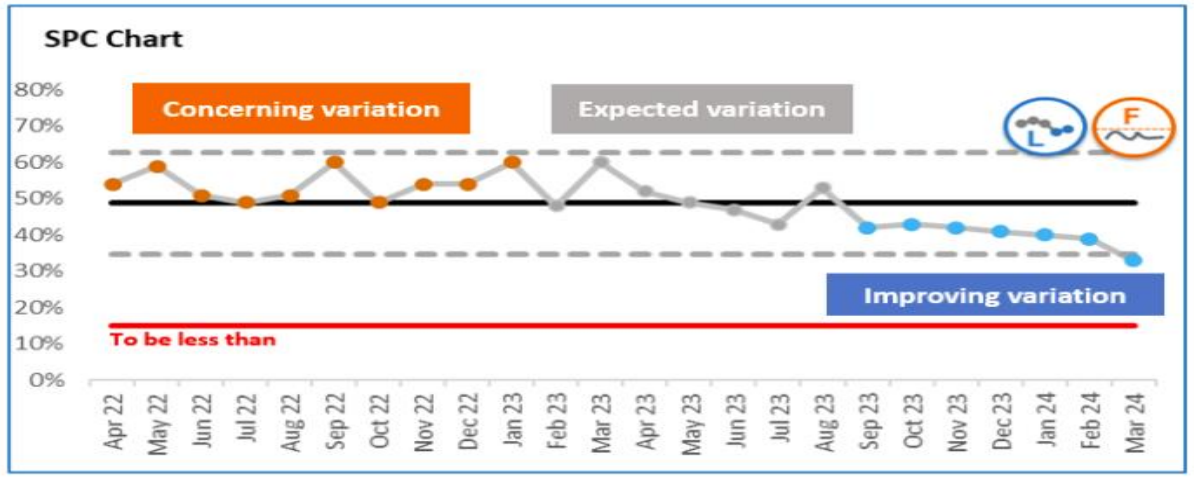
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be react noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



UPL

Average

LPL

Target

The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Risk scoring process

Step 1

Guide to Risk scoring		Target Assurance		
		Consistently Achieve	Achieve at Random	Consistently off target
Variation	Improving	Risk: LOW	Risk MED	Risk MED
	Normal Variation	Risk: LOW	Risk MED	Risk: HIGH
	Concern	Risk MED	Risk: HIGH	Risk: HIGH

Step 2

Risk level is worked out using the SPC variation and target assurance in step 1. Then a step 2 test is applied.

- Is the metric something without a target such as safety incidents and we want to continue to monitor the actions
- A common-sense check of the SPC interpretation and risk may lead to a slight adjustment of the risk

Step 3

Risk score of med or high means that an exception report pages is added to the IPR with a full SPC graph, Care Group data breakdown, reasons for performance issue, list of actions and expected improvement timescales.

Headline SPC performance measure summary

Reporting Period: May-2025

Target assurance

Variation	Consistently achieve	Achieve at Random	Consistently off target	No Target
Improvement		• Did you feel safe? • Active Inappropriate Out of Areas	• How as your experience? (FFT) • % of patients with a Safety Plan • Records of Capacity/CTT at point of detention	• MRE Restraints • Prone Restraints • Long Term Seg & prolonged seclusion
Normal Variation	• % PLT Ward referrals seen within 24hrs	• How was the care we provided? • Rights at point of Detention • % Adult inpatients discharged with LOS >60 days • % Older Adult inpatients discharged with LOS >90 days • Crisis % Very urgent seen within 4 hours • % PLT ED referrals seen within 1hr • All staff WTEs against plan	• Sickness • Bed Occupancy • % 4 week or less to treatment (WAAOP)	• Assaults on Patients • Assaults on Staff
Concern	• EIP – Starting Treatment in 14 days	• Crisis % Urgent seen within 24 hours	• Appraisal rate • Clinically Ready for Discharge • % Waiting 4 weeks or less to receive help (CYPS)	

Key exceptions – improvement commentary

Reporting Period: May-2025

% waiting < 4 weeks to treatment – Adult & Older Services

What the data and intelligence tells us about the challenges

- The target is currently internally set at 75% as part of medium-term trajectory to move from 18 weeks to the new 4 week wait. In May 2025, the performance was 23.0%, this has come down from a peak of 40% in September 2024. The performance two years ago was 20%.
- This measure remains off target, however, the Trust benchmark highest compared to all Mental Health Provider across several waiting times metrics such as numbers waiting over 52, 72 and 104 weeks.
- The metric under 4 weeks is very challenging, teams have moved from a pathway that was to have two contacts within 18 weeks to an intervention or care plan and a baseline assessment within 4 weeks. We also benchmark high for compliance with this method.

Improvement Actions

- Bi-monthly Access Oversight Group happens with CBU's and will refocus on improving performance delivery and data quality.
- There are fortnightly waiting list meetings overseen by each team with a focus on improving waiting times using the dashboards, these are supported by the Heads of Commissioning and Quality Assurance.

Expected impact and by when

Expected impact will be improvement across 2025/26.

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

What the data and intelligence tells us about the challenges

- The target is currently internally set at 55% as part of medium-term trajectory to move from 18 weeks to the new 4 week wait. At May, the performance is 7.5%, this has come down from around 15% a year ago.
- 20% of CYPS on a Mental Health or Learning Disability pathway were seen within 4 weeks and only 4% of patients on a Neurodevelopmental Pathway were seen within 4 weeks.
- This measure remains low due to neurodevelopmental referrals demand increasing four times and outstripping demand capacity. Performance in Newcastle and Gateshead is most challenged but North Cumbria also have a high number of patients waiting over 4 weeks.
- The metric will include all patients every month who have not been seen and are on long waiting lists so this is not a measure that can be rectified without tackling the large waiting lists.

Improvement Actions

- Discussions with the ICB are taking place at a strategic level to focus on taking some of the learning from the ADHD taskforce report published in June which recognises the needs for a greater focus on services outside of secondary care whilst also improving secondary services
- This strategic group of partners have developed revised clinical thresholds which will define access to secondary mental health services and alternative providers so most of the need can be met outside the Trust which will reduce Trust demand and improve our waits.

Expected impact and by when

The impact of any improvement actions is going to be over years not months due to the size and scale of the impact of the increased demand of Neurodevelopmental CYPS.

Key exceptions – improvement commentary

Reporting Period: May-2025

Crisis % Urgent seen within 24 hours

What the data and intelligence tells us about the challenges

- In May 55.6% patients were see within 4 hours. The performance has been 10% above the average for the last 4 months.
- Northumberland and Tyneside had the lowest performance at 40% and North Cumbria had the highest at 77%. There are only low numbers that make up the metric so the figure can fluctuate more than other metrics.
- There are some challenges in demand and capacity and the peaks in demand can mean seeing patients in time is challenging. There is also the need to staff 136 suites that can reduce capacity to see Crisis referrals.

Improvement Actions

- A 136-suite paper has been approved that will enable the Crisis Team to focus on crisis referrals and improve the performance.
- Improve the standardisation of referral recording across teams supported by Access Oversight sub-group because a few issues can have a big impact with small numbers.
- The staffing shortage in 111 service due to unexpected demand has impacted Crisis Performance. This has impacted the crisis performance. To tackle this issue, a recruitment plan has been established.

Expected impact and by when

- It is expected that these measures will take a few months to implement but will have an impact on current performance within quarter 3 2025/26

Clinically Ready for Discharge

What the data and intelligence tells us about the challenges

- In May 13.3% of patients were Clinically Ready for Discharge (CRFD). The performance has been about this level for 6 months. 18-24 months ago the Trust was consistently around 10%, the target is 7.5%. The % CRFD bed days continues to remain high and a significant pressure.
- In the last six months there has been a recent significant reduction in the CRFD in Adult Acute wards and a recent uptick in the Older Adults and Rehabilitation wards.
- Most patients are awaiting housing or a care package. There system wide challenges with complex discharges and enabling appropriate support and care packages.

Improvement Actions

- The Community, Psychiatric Liaison, and Crisis Teams have worked collaboratively to manage increased inpatient demand. Their efforts have supported the repatriation of out-of-area patients, reduced inappropriate hospital admissions, and helped minimise discharge delays. While delayed discharges remain high, there has been a noticeable reduction in the acute pathway. Comprehensive improvement is being implemented across all operational areas to address these delays and improve patient flow, with a particular focus on strengthening the Hospital to Home pathway
- The Trust will continue to be engaged in the Multi-agency Response Group (MaRG) incorporating local authorities, ICB and CNTW teams continues to be in place. Internal review of the MaRG meeting & the terms of reference take place based on learning to date.

Expected impact and by when

- The impact of the above actions are being monitored daily with anticipated improvement to be September onwards the benefits of the new ways of working become enhanced

Key exceptions – improvement commentary

Reporting Period: May-2025

Appraisal rate

What the data and intelligence tells us about the challenges

- The target for Appraisal rate is 85% and the Trust has not been above 80% for 2 years and is therefore classed as consistently off target.
- The performance has not dropped below 72% for 2 years but in the last 6 months has fallen below the 24-month average and is therefore classed as concern in terms of variation across the 2 years. This decline is due to concerning trends in Specialist Care Group and Corporate/Support Services.
- The Performance is at 73.8% against a target of 85% for May 2025. Specialist Care Group and Corporate/Support Services are furthest from the target.

Improvement Actions

- Deep dive of appraisal performance at The Workforce Business Delivery Group and all Corporate Teams and Care Groups are producing a trajectory and improvement plan to rectify the current position over the next quarter.
- Corporate Teams and Care Groups are reviewing areas under 50% compliance and provide plans for improvement into July 2025.
- Corporate appraisal rates shared with Executive Director who is performance managing across the directorates.

Expected impact and by when

It is expected that performance will improve and be on target by quarter three.

Sickness Rate

The data for April not May, it's one month behind to allow time for records to be updated on ESR

What the data and intelligence tells us about the challenges

- The current performance is 6.6% at April 2025 against a 5% target.
- CNTW sickness rate has fluctuated with normal variation between 6% and 7% for the last two years.
- The rate is in line with peer Trusts but in the highest quartile for Mental Health Trusts and was in this quartile in 2017.

Improvement Actions

- Deep dive of sickness performance at The Workforce Business Delivery Group and all Corporate Teams and Care Groups are producing a trajectory and improvement plan to rectify the current position over the next quarter. Targeted improvement work though the Resources and Performance Group to:
    a) focus on teams with 15% or more sickness
    b) Target support to staff with 3 or more absences per revised policy
- Promote and continue to implement the Trust health and wellbeing offer. There is also Health and Growth Accelerator Funding and support for a Regional Wellbeing hub.
- Robust management of the Optima Health contract.
- New Health Wellbeing and attendance policy training underway

Expected impact and by when

It is expected that performance will improve by quarter three. There is a commitment to the ICB to reduce sickness by 1% in 25/26.

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: May-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	88.5%	90%	CNTW Std	Med (Monitoring)	Improved in the month	SR
	C02	How was the care we provided?	Normal Variation	Achieve at Random	87.9%	90%	CNTW Std	Med (Monitoring)	Deteriorated in the month	SR
	C03	Did you feel safe?	Improvement	Achieve at Random	91.9%	90%	CNTW Std	Low (On Track)	Reported consistently above target for 14 months	SR
People	P01	Sickness in Month	Normal Variation	Consistently Off Target	6.6%	5%	NHSE Std	High (Action)	Deteriorated in the month, excludes NTW Solutions data	LS
		The training metrics are now shown as individual measures in their own page								
	P04	Appraisal rate	Concern	Consistently Off Target	73.8%	85%	CNTW Std	High (Action)	Remains off target and has deteriorated in the month - excludes NTWS	LS
	P05	% Clinical Supervision completed	SPC n/a	SPC n/a	81.9%	80%	CNTW Std	Low (On Track)	81.9% is the reported position as at 31st May 2025	LS
Quality Care	Q01	MRE Restraints	Improvement	SPC not applicable	2	n/a	n/a	Med (Monitoring)	Lowest position reported in 24 months	SR
	Q02	Prone Restraints	Improvement	SPC not applicable	11	n/a	n/a	Med (Monitoring)	Position improved, below lower control limit for 9th consecutive month	SR
	Q03	Long term segregation and prolonged seclusion	Improvement	SPC not applicable	13	n/a	n/a	Med (Monitoring)	Improved in the month, remains below average (14 reported April 25)	SR
	Q04	Assaults on Patients	Normal Variation	SPC not applicable	175	n/a	n/a	Med (Monitoring)	Increased in the month	RN
	Q05	Assaults on staff	Normal Variation	SPC not applicable	465	n/a	n/a	Med (Monitoring)	No change in the month (465 reported April 2025)	RN
	Q06	% of patients with a Safety Plan	Improvement	Consistently Off Target	85.9%	100%	CNTW Std	Med (Monitoring)	Position increased in the month	RN
	Q07	Reducing incidents of self-harm	Normal Variation	SPC not applicable	1,317	n/a	n/a	Med (Monitoring)	Position decreased in the month	RN
	Q08	Rights at Point of Detention	Normal Variation	Achieve at Random	93.0%	100%	CNTW Std	Med (Monitoring)	Performance continues to flucuate, improved in the month	RN
	Q09	Record of Capacity/ CTT at point of detention	Improvement	Consistently Off Target	75.6%	100%	CNTW Std	High (Action)	Remains consistently off target, increased in the month	RN
Person Led Care	A01	Active Inappropriate Out of Area Placements	Improvement	Achieve at Random	0	0	NHSE LTP	Med (Monitoring)	There were no active Out of Area Placements at the end of May	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Normal Variation	Consistently Off Target	92.7%	85%	NHSE Std	High (Action)	Improved in the month but remains above target	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	Achieve at Random	29.7%	20%	CNTW Std	Med (Monitoring)	Deteriorated in the month, reported above target	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	42.5%	40%	CNTW Std	Med (Monitoring)	Deteriorated in the month, reported above target	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Concern	Consistently Off Target	13.3%	7.5%	NHSE Std	High (Action)	Remains off track, improved in the month	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	Achieve at Random	55.6%	60%	CNTW Traj	Med (Monitoring)	30 out of 54 very urgent referrals seen within 4 hours	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Concern	Achieve at Random	75.6%	85%	CNTW Std	High (Action)	397 out of 525, improved in the month but remains below target	RD
	A08	% PLT ED Referrals seen within 1 hour	Normal Variation	Achieve at Random	84.9%	80%	CNTW Std	Low (On Track)	Improved in the month, reported above the internal target	RD
	A09	% PLT Ward Referrals seen within 24 hours	Normal Variation	Consistently Achieve	96.3%	85%	CNTW Std	Low (On Track)	Reported consistently above the internal target	RD
	A10	% Waiting 4 wks or less to treatment (WAAOP)	Normal Variation	Consistently Off Target	23.0%	75%	CNTW Traj	High (Action)	77.0% (2,310 of 3,000) have been waiting longer than 4 weeks	RD
	A11	% Waiting 4 wks or less to receive help (CYPS)	Concern	Consistently Off Target	7.5%	55%	CNTW Traj	High (Action)	92.5% (8,708 of 9,414) have been waiting longer than 4 weeks	RD
	A12	EIP – starting treatment in 14 days	Concern	Consistently Achieve	68.2%	60%	CNTW Std	Med (Monitoring)	Above target, improved in May following a deterioration in April 25	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC not applicable	SPC not applicable	£2.6m	-£0.9m	n/a	Low (No Target)	The Trust is reporting a 2.6m surplus at month 2, due to land sale	KS
	S02	Income & Expenditure Forecast	SPC not applicable	SPC not applicable	-£4.4m	£3.3m	n/a	Low (No Target)	The Trust has delivered against the requirements at month 2	KS
	S03	All staff WTEs	Normal Variation	Achieve at Random	8,611	8,557	CNTW Traj	Med (Monitoring)	The Trust was 54 WTE over established in month 2	KS
	S04	Capital spend compared to plan (£)	SPC not applicable	SPC not applicable	£0.7m	£0.5m	n/a	Low (No Target)	Capital programme is behind the Trust annual plan at month 2	KS
	S05	Cash balance compared to plan (£)	SPC not applicable	SPC not applicable	£38.3m	£26.2m	n/a	Low (No Target)	The Trust cash balance is higher than plan at month 2	

Training - Summary Overview

Reporting Period: May-2025

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	Concern	Consistently Achieve	89.1%	90%	CNTW Std	8,016	8,994	Med (Monitoring)
TA02	Corporate Induction	Normal Variation	Consistently Achieve	96.2%	95%	CNTW Std	8,653	8,994	Low (On Track)
TA03	Local Induction	Improvement	Consistently Off Target	94.9%	95%	CNTW Std	8,526	8,986	Med (Monitoring)
TA04	Safeguarding Adults Level 1	Normal Variation	Consistently Achieve	94.9%	85%	CNTW Std	1,602	1,689	Low (On Track)
TA05	Safeguarding Children Level 1	Concern	Consistently Achieve	94.1%	85%	CNTW Std	1,589	1,689	Med (Monitoring)
TA06	Fire	Improvement	Consistently Achieve	89.0%	85%	CNTW Std	8,003	8,994	Low (On Track)
TA07	Equality & Diversity Introduction	Improvement	Consistently Achieve	95.2%	85%	CNTW Std	8,561	8,994	Low (On Track)
TA08	Health & Safety	Improvement	Consistently Achieve	95.2%	85%	CNTW Std	8,558	8,994	Low (On Track)
TA09	Infection Prevention & Control (IPC)	Concern	Consistently Achieve	93.3%	85%	CNTW Std	8,388	8,994	Med (Monitoring)
TA10	Moving & Handling Awareness Training	Improvement	Consistently Achieve	93.7%	85%	CNTW Std	8,431	8,994	Low (On Track)
TA11	Web Risk Register	SPC not applicable	SPC not applicable	73.1%	85%	CNTW Std	616	843	Low (On Track)

Clinical Staff Priority Training

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TC01	Clinical Risk and Suicide Prevention	Improvement	Consistently Off Target	84.7%	85%	CNTW Std	3,396	4,008	Med (Monitoring)
TC02	Biopsychosocial at Risk Assess. & Safety Planning	Normal Variation	Achieve at Random	91.9%	85%	CNTW Std	3,683	4,008	Low (On Track)
TC03	Resuscitation L2 Adult Basic Life Support	Improvement	Consistently Off Target	80.7%	85%	CNTW Std	1,500	1,860	High (Action)
TC04	Resuscitation L3 Adult Immediate Life Support	Improvement	Consistently Off Target	72.7%	85%	CNTW Std	2,457	3,379	High (Action)
TC05	Resuscitation L3 Paediatric Immed Life Support	Improvement	Consistently Off Target	37.5%	85%	CNTW Std	15	40	High (Action)
TC06	Resuscitation L2 Paediatric Basic Life Support	Improvement	Consistently Off Target	77.2%	85%	CNTW Std	458	593	High (Action)
TC07	PMVA Basic	Improvement	Consistently Off Target	78.4%	85%	CNTW Std	1,988	2,536	High (Action)
TC09	Engagement & Observation	Improvement	Consistently Off Target	88.0%	90%	CNTW Std	2,941	3,343	Med (Monitoring)
TC10	Dysphagia Awareness	Improvement	Consistently Off Target	88.9%	85%	CNTW Std	2,268	2,550	Med (Monitoring)
TC11	Autism Core Capabilities: Tier 1 & 2	SPC not applicable	SPC not applicable	48.2%	60%	CNTW Traj	3,116	6,463	High (Action)
TC12	Learning Disability Tier 1	SPC not applicable	SPC not applicable	37.5%	50%	CNTW Traj	2,426	6,463	High (Action)

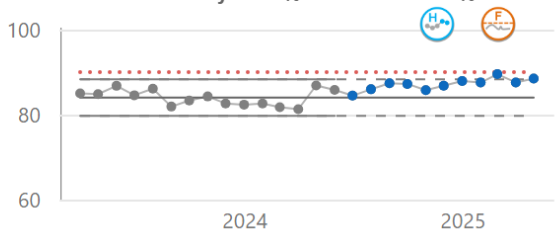
Commitments to our Carers and Patients

Reporting Period: May-2025

How was your experience? (FFT)

Med (Monitoring)

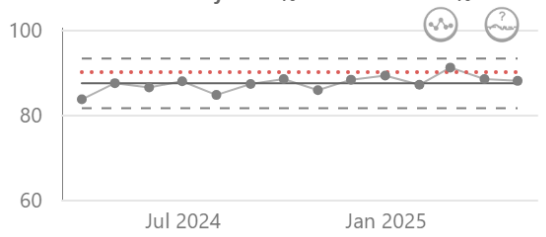
Ref: C01 May: 88.5% CNTW Std: 90%



How was the care we provided?

Med (Monitoring)

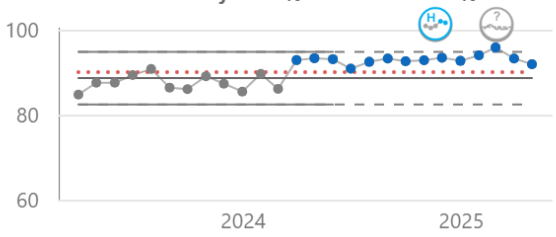
Ref: C02 May: 87.9% CNTW Std: 90%



Did you feel safe?

Low (On Track)

Ref: C03 May: 91.9% CNTW Std: 90%



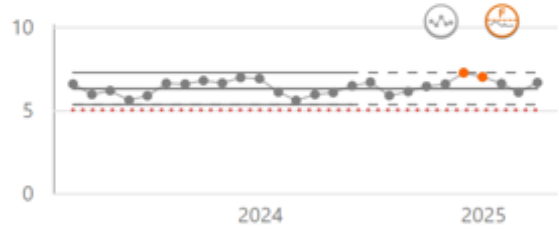
Great Place to Work

Reporting Period: May-2025

Sickness in Month

High (Action)

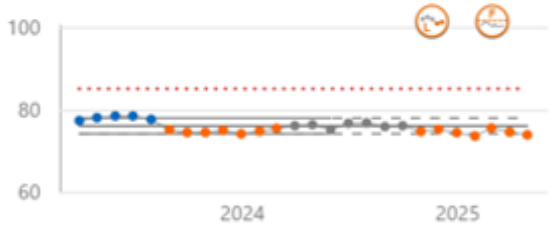
Ref: P01 April: 6.6% NHSE Std: 5%



Appraisal rate

High (Action)

Ref: P04 May: 73.8% CNTW Std: 85%



Great Place to Work

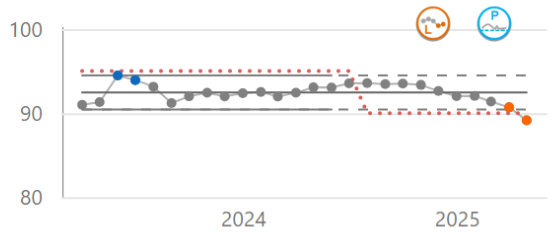
All Staff Priority Training

Reporting Period: May-2025

Information Governance

Med (Monitoring)

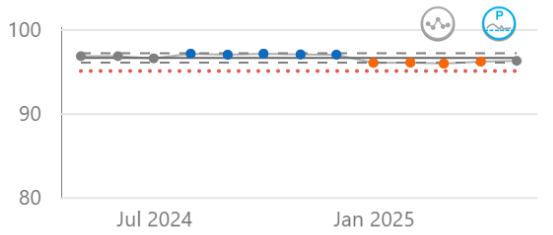
Ref: TA01 May: 89.1% CNTW Std: 90%



Corporate Induction

Low (On Track)

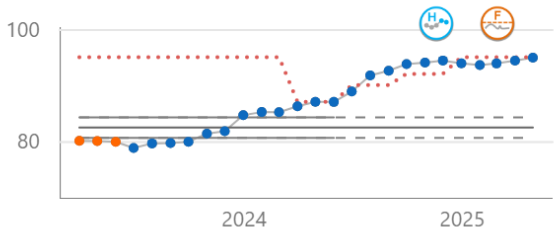
Ref: TA02 May: 96.2% CNTW Std: 95%



Local Induction

Med (Monitoring)

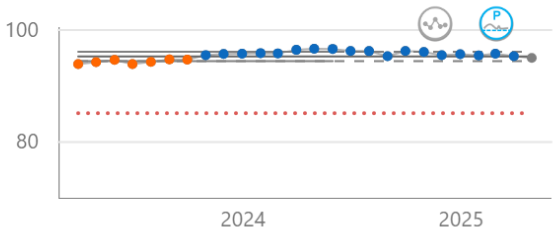
Ref: TA03 May: 94.9% CNTW Std: 95%



Safeguarding Adults Level 1

Low (On Track)

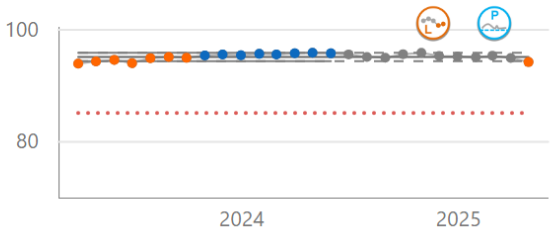
Ref: TA04 May: 94.9% CNTW Std: 85%



Safeguarding Children Level 1

Med (Monitoring)

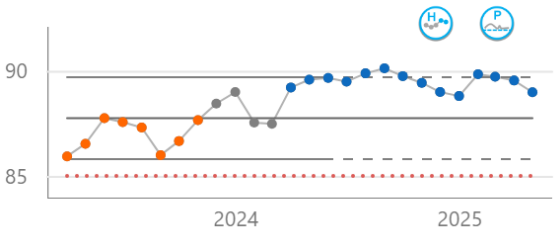
Ref: TA05 May: 94.1% CNTW Std: 85%



Fire

Low (On Track)

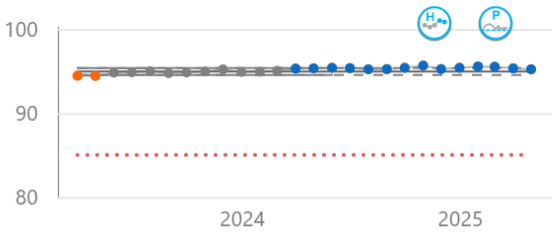
Ref: TA06 May: 89.0% CNTW Std: 85%



Equality & Diversity Introduction

Low (On Track)

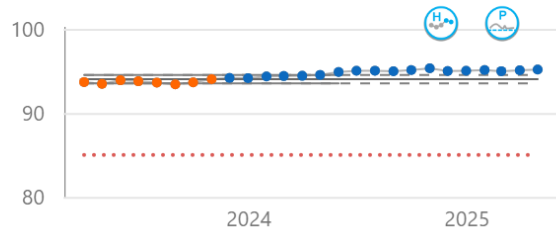
Ref: TA07 May: 95.2% CNTW Std: 85%



Health & Safety

Low (On Track)

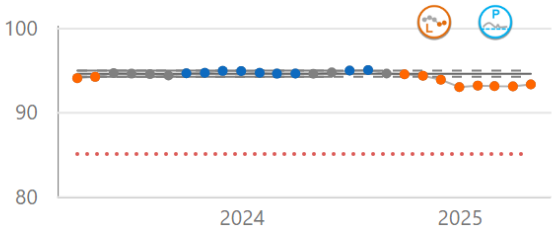
Ref: TA08 May: 95.2% CNTW Std: 85%



Infection Prevention & Control (IPC)

Med (Monitoring)

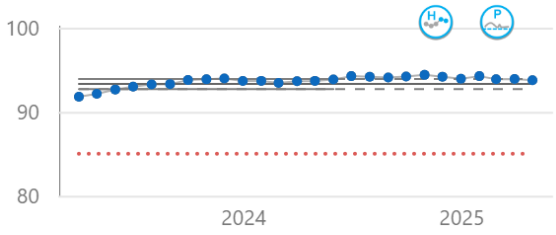
Ref: TA09 May: 93.3% CNTW Std: 85%



Moving & Handling Awareness Training

Low (On Track)

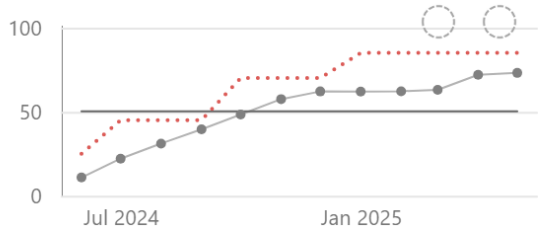
Ref: TA10 May: 93.7% CNTW Std: 85%



Web Risk Register

Low (On Track)

Ref: TA11 May: 73.1% CNTW Std: 85%



Great Place to Work

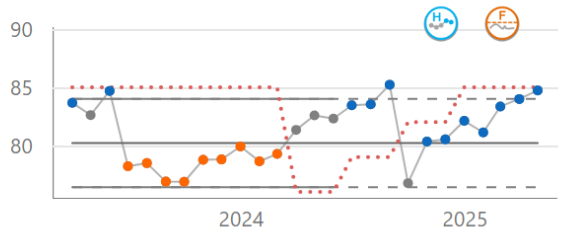
Clinical Staff Priority Training

Reporting Period: May-2025

Clinical Risk and Suicide Prevention

Med (Monitoring)

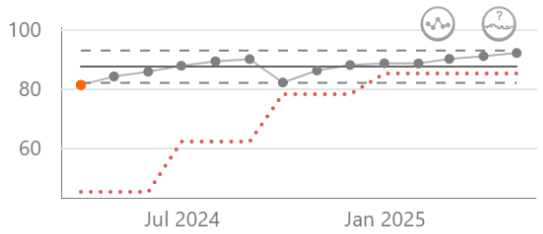
Ref: TC01 May: 84.7% CNTW Std: 85%



Biopsychosocial at Risk Assess. & Safety Planning

Low (On Track)

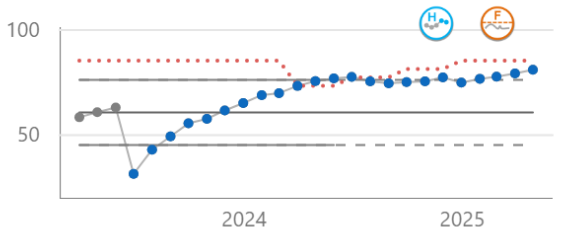
Ref: TC02 May: 91.9% CNTW Std: 85%



Resuscitation L2 Adult Basic Life Support

High (Action)

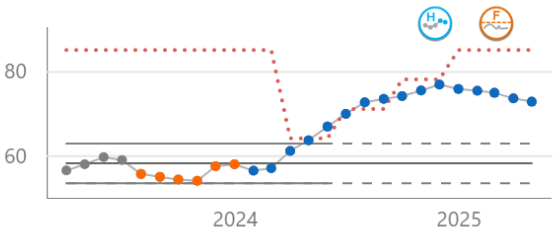
Ref: TC03 May: 80.7% CNTW Std: 85%



Resuscitation L3 Adult Immediate Life Support

High (Action)

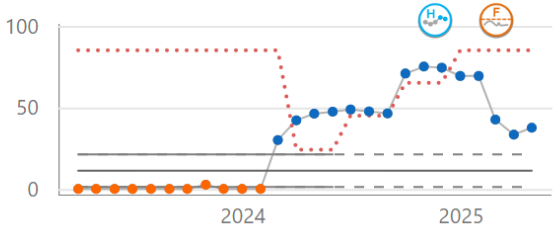
Ref: TC04 May: 72.7% CNTW Std: 85%



Resuscitation L3 Paediatric Immed Life Support

High (Action)

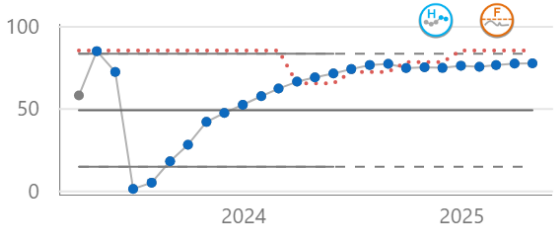
Ref: TC05 May: 37.5% CNTW Std: 85%



Resuscitation L2 Paediatric Basic Life Support

High (Action)

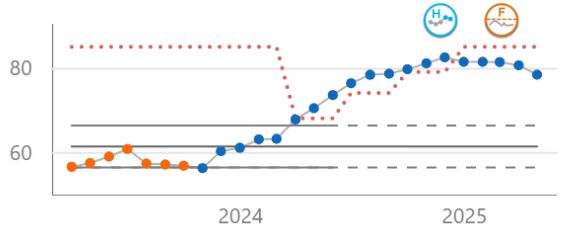
Ref: TC06 May: 77.2% CNTW Std: 85%



PMVA Basic

High (Action)

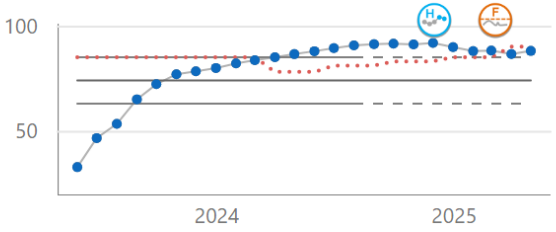
Ref: TC07 May: 78.4% CNTW Std: 85%



Engagement & Observation

Med (Monitoring)

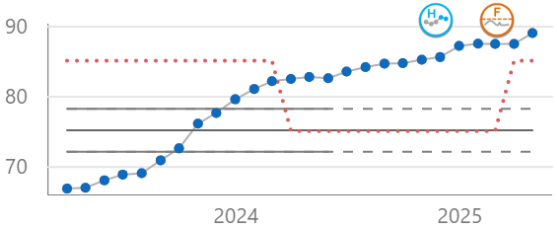
Ref: TC09 May: 88.0% CNTW Std: 90%



Dysphagia Awareness

Med (Monitoring)

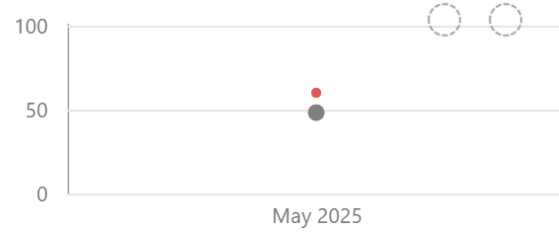
Ref: TC10 May: 88.9% CNTW Std: 85%



Autism Core Capabilities: Tier 1 & 2

High (Action)

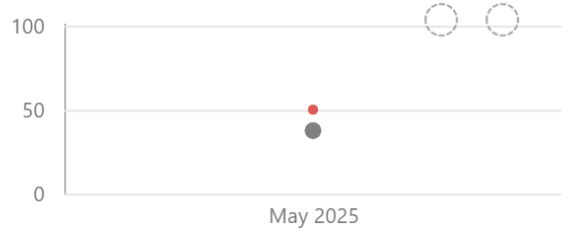
Ref: TC11 May: 48.2% CNTW Traj: 60%



Learning Disability Tier 1

High (Action)

Ref: TC12 May: 37.5% CNTW Traj: 50%



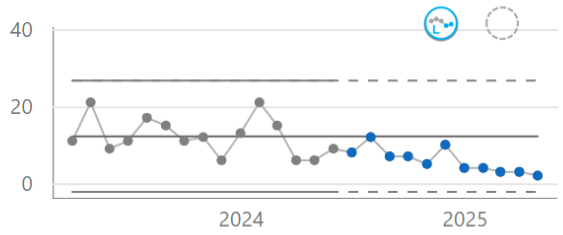
Quality Care, Every Day

Reporting Period: May-2025

MRE Restraints

Med (Monitoring)

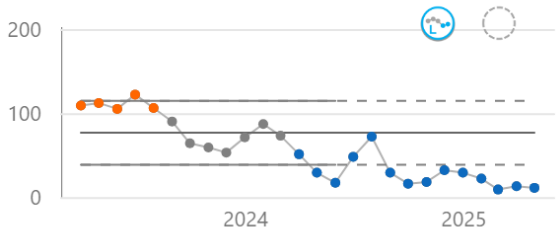
Ref: Q01 May: 2 Plan: n/a



Prone Restraints

Med (Monitoring)

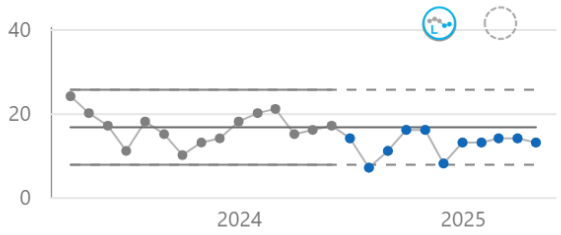
Ref: Q02 May: 11 Plan: n/a



Long term segregation and prolonged seclusion

Med (Monitoring)

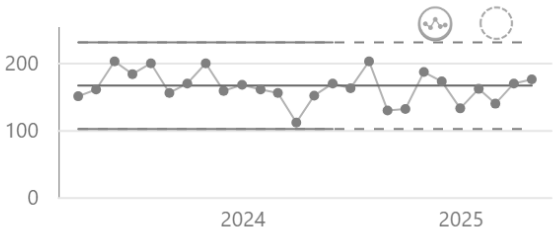
Ref: Q03 May: 13 Plan: n/a



Assaults on Patients

Med (Monitoring)

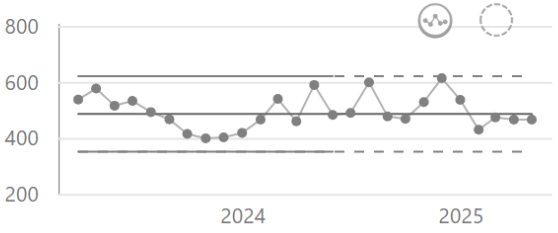
Ref: Q04 May: 175 Plan: n/a



Assaults on staff

Med (Monitoring)

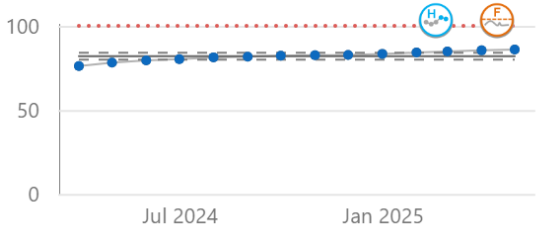
Ref: Q05 May: 465 Plan: n/a



% of patients with a Safety Plan

Med (Monitoring)

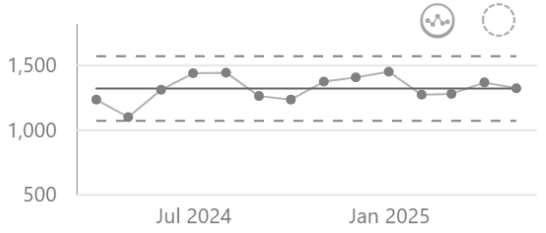
Ref: Q06 May: 85.9% CNTW Std: 100%



Reducing incidents of self-harm

Med (Monitoring)

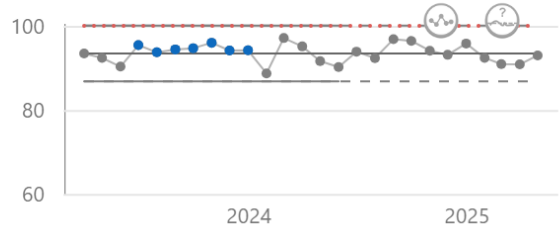
Ref: Q07 May: 1,317 Plan: n/a



Rights at Point of Detention

Med (Monitoring)

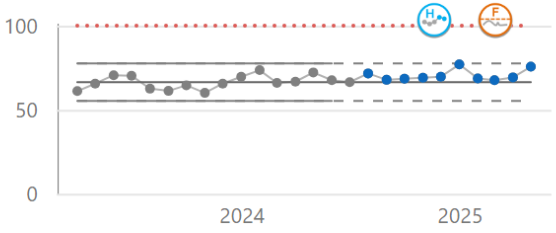
Ref: Q08 May: 93.0% CNTW Std: 100%



Record of Capacity/ CTT at point of detention

High (Action)

Ref: Q09 May: 75.6% CNTW Std: 100%



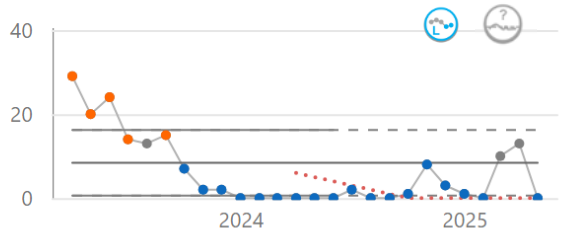
Person-led Care, when and where needed

Reporting Period: May-2025

Active Inappropriate Out of Area Placements

Med (Monitoring)

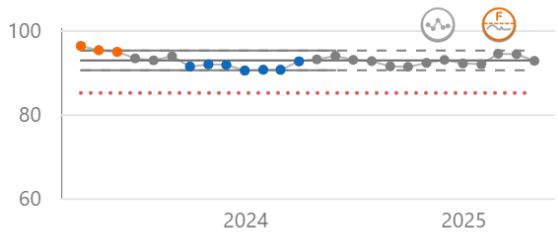
Ref: A01 May: 0 NHSE LTP: 0



Bed Occupancy including leave (open beds on RiO)

High (Action)

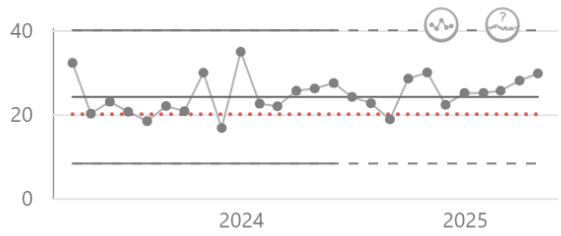
Ref: A02 May: 92.7% NHSE Std: 85%



% Adult inpatients discharged with LOS > 60 days

Med (Monitoring)

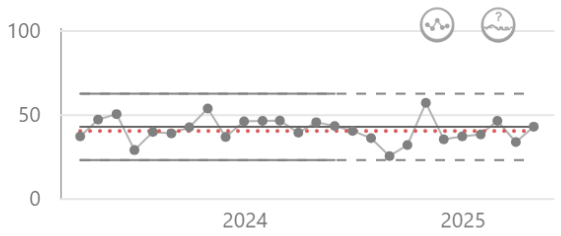
Ref: A03 May: 29.7% CNTW Std: 20%



% OP inpatients discharged with LOS > 90 days

Med (Monitoring)

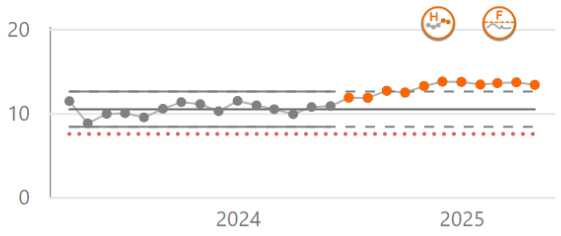
Ref: A04 May: 42.5% CNTW Std: 40%



Clinically Ready for Discharge (formerly DTOC)

High (Action)

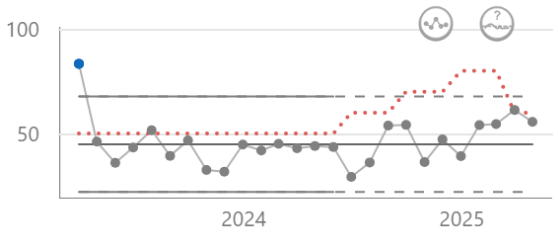
Ref: A05 May: 13.3% NHSE Std: 7.5%



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

Med (Monitoring)

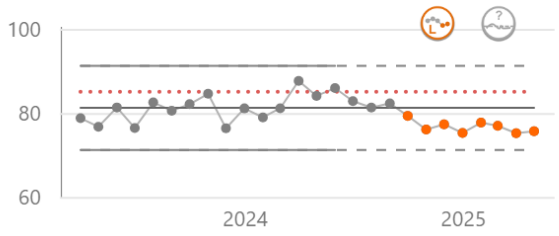
Ref: A06 May: 55.6% CNTW Traj: 60%



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

High (Action)

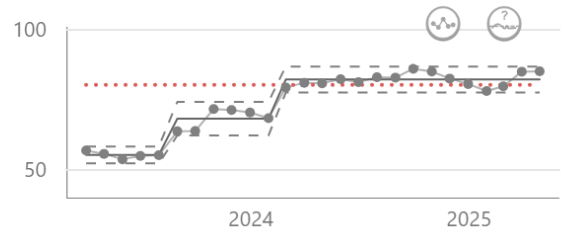
Ref: A07 May: 75.6% CNTW Std: 85%



% PLT ED Referrals seen within 1 hour

Low (On Track)

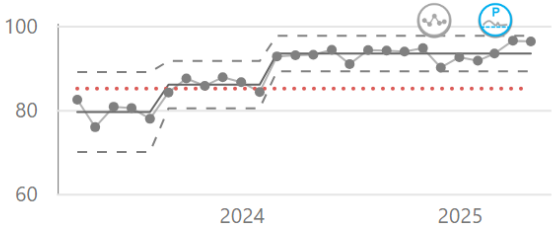
Ref: A08 May: 84.9% CNTW Std: 80%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

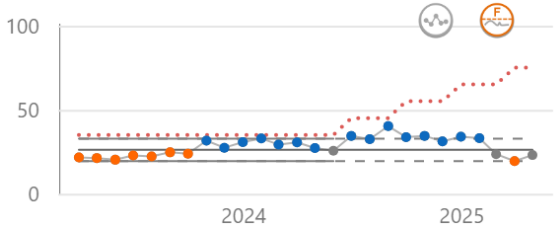
Ref: A09 May: 96.3% CNTW Std: 85%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

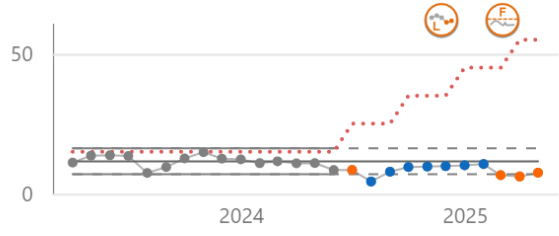
Ref: A10 May: 23.0% CNTW Traj: 75%



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

High (Action)

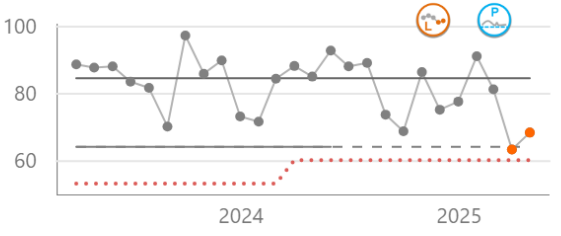
Ref: A11 May: 7.5% CNTW Traj: 55%



EIP – starting treatment in 14 days

Med (Monitoring)

Ref: A12 May: 68.2% CNTW Std: 60%



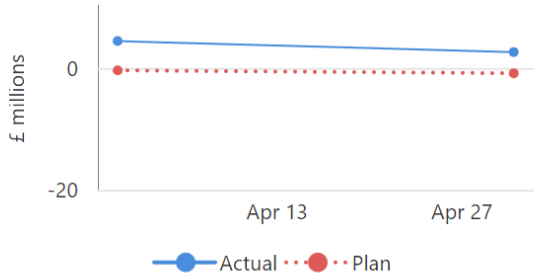
Sustainable for the Long Term

Reporting Period: May-2025

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

Low (No Target)

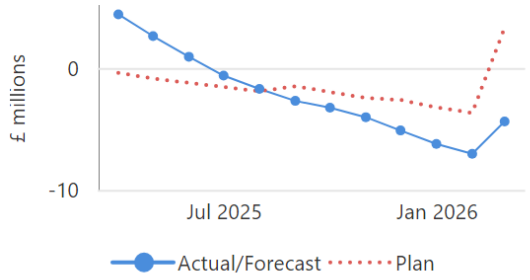
Ref: S01 May: £2.6m Plan: -£0.9m



Income & Expenditure Forecast

Low (No Target)

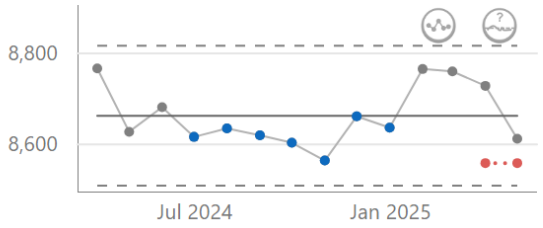
Ref: S02 March: -£4.4m Plan: £3.3m



All staff WTEs

Med (Monitoring)

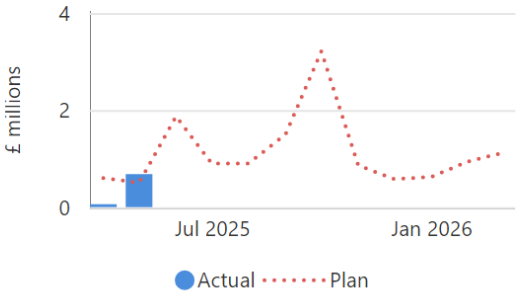
Ref: S03 May: 8,611 CNTW Traj: 8,557



Capital spend compared to plan (£)

Low (No Target)

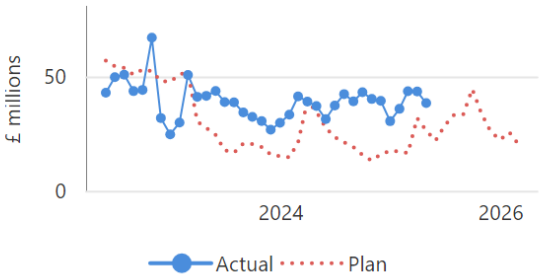
Ref: S04 May: £0.7m Plan: £0.5m



Cash balance compared to plan (£)

Low (No Target)

Ref: S05 May: £38.3m Plan: £26.2m



SUPPORTING INFORMATION AND FURTHER ANALYSIS ON METRICS

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

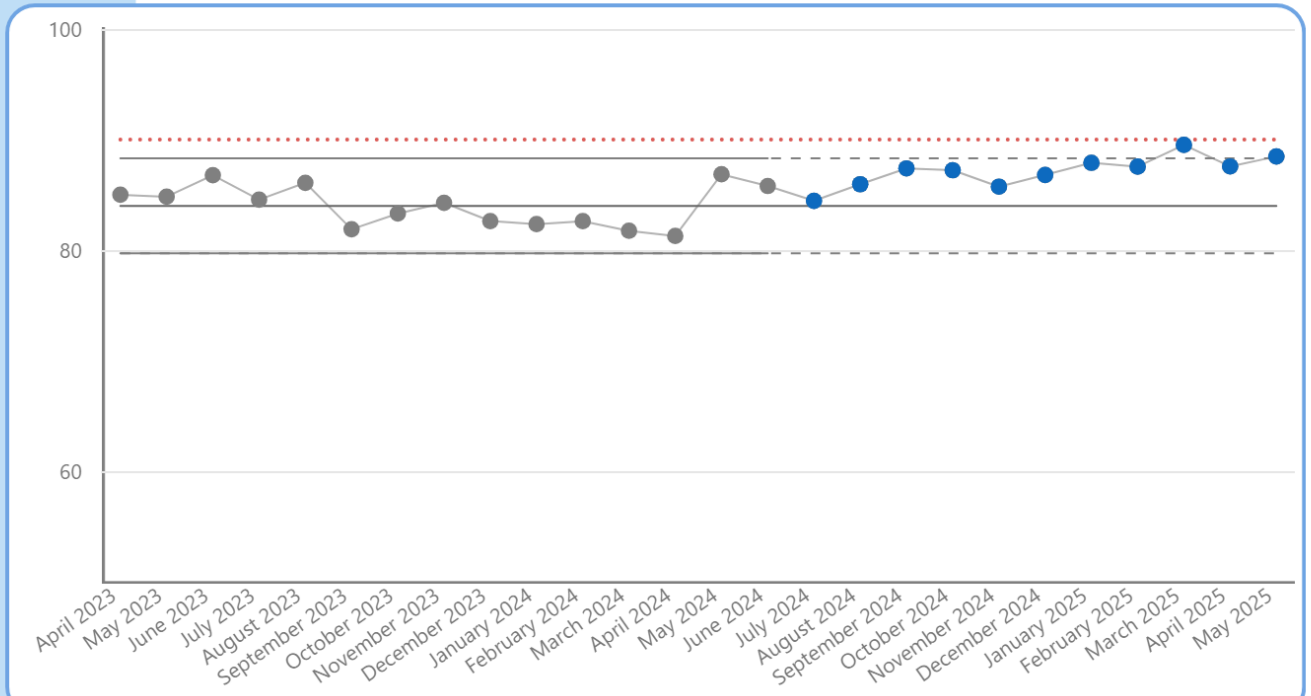
88.5%

tgt. 90%
n. 537
d. 607

Improvement
This indicator is increasing which shows improvement

Consistently Off Target
The target for this indicator is outside 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	87.6%	304	347	90%	Improvement	Achieve at Random
Inpatient Care Group	94.7%	54	57	90%	Normal Variation	Achieve at Random
Specialist Care Group	87.8%	172	196	90%	Normal Variation	Achieve at Random
Support & Corporate	100.0%	7	7	90%	SPC not applicable	SPC not applicable

Feedback

What the chart tells us

Performance was reported at 88.5% for May which is an increase from April (87.6%). Without change, we will remain consistently off target.

Root Cause of the performance issue

- There were 37 (6.1%) negative experiences reported of the 607 responses to this question. This is a deterioration from 31 (5.5%) in April 2025.
- There are no teams with high numbers of negative experiences this month. The CNTW Access Hub reported the highest negative responses (5) followed by North Cumbria CYPS ADHD (4).

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 this was implemented 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)

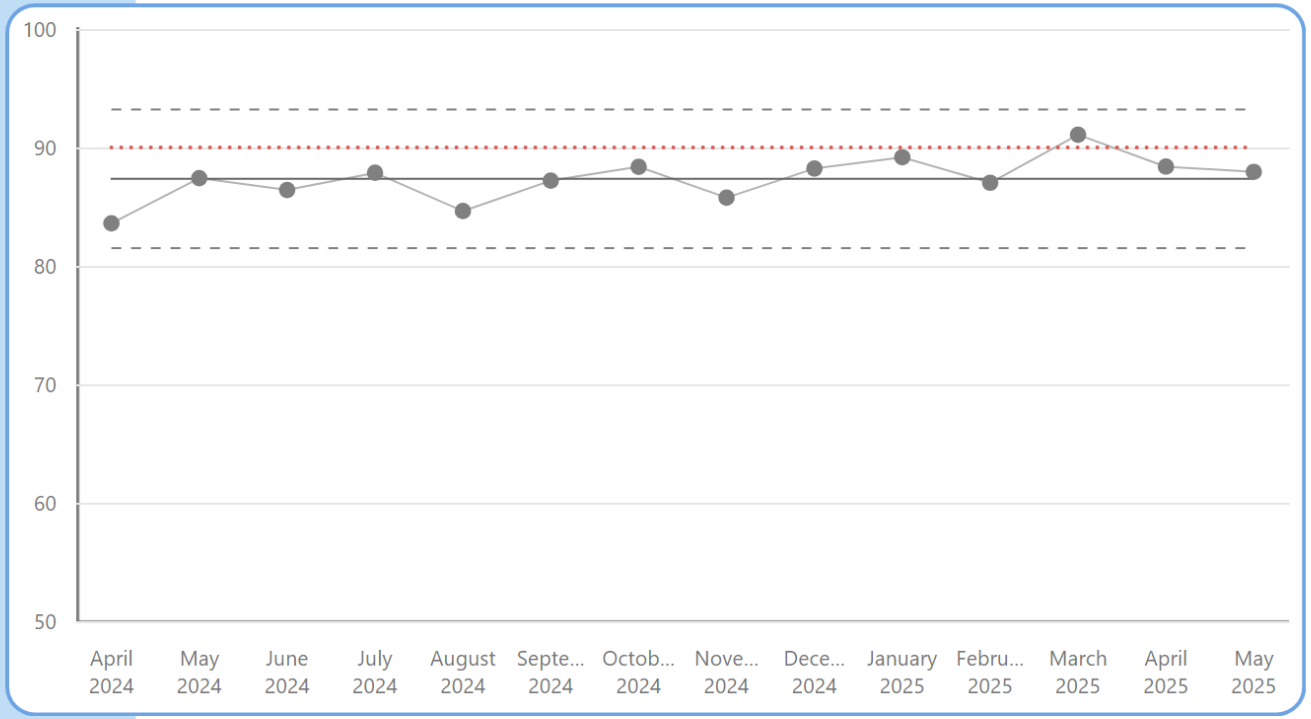
tgt. = target n. = numerator d. = denominator

87.9%	tgt.	90%
	n.	525
	d.	597

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

Achieve at Random
The target for this indicator is within the upper and lower 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	87.4%	297	340	90%	Normal Variation	Achieve at Random
Inpatient Care Group	89.5%	51	57	90%	Normal Variation	Achieve at Random
Specialist Care Group	88.1%	170	193	90%	Normal Variation	Achieve at Random
Support & Corporate	100.0%	7	7	90%	SPC not applicable	SPC not applicable

Feedback

What the chart tells us

Performance was reported at 87.9% for May, which is a deterioration from April (88.4%).

Root Cause of the performance issue

- 597 people responded to this question, with 525 reporting a good or very good experience of the care provided.
- 30 respondents reported a poor experience (17 very poor and 13 poor) an improvement from 39 in April from 509 responses.
- The CNTW Access Hub received the highest number of 'Very Poor' responses this month (3)

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. May saw 45 posters created (56 in April). This process 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)

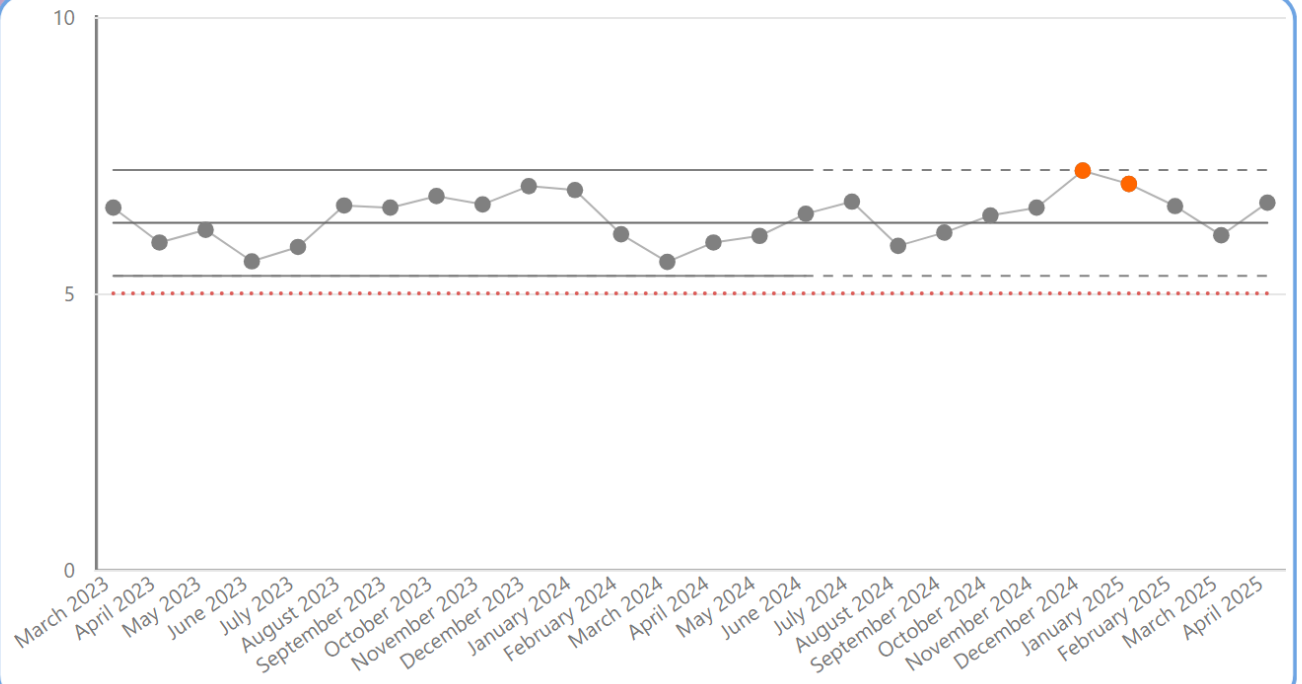
tgt. = target n. = numerator d. = denominator

6.6% tgt. 5% n. 14,739 d. 222,002

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

Consistently Off Target
The target for this indicator is outside 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%	6,223	90,418	5%	Concern	Consistently Off Target
Inpatient Care Group	8.3%	4,136	49,904	5%	Concern	Consistently Off Target
Specialist Care Group	6.6%	3,498	52,755	5%	Normal Variation	Consistently Off Target
Support & Corporate	3.1%	881	28,925	5%	Normal Variation	Consistently Achieve

Feedback

What the chart tells us

The chart shows the confirmed sickness for April 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

- Targeted improvement work though the Resources and Performance Group to
  a) focus on teams with 15% or more sickness
  b) target support to staff with 3 or more absences per revised policy
- 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
- Sourcing of system to help management of Short-Term sickness

Expected impact and by when

ICB agreed 1% reduction by end of 25/26

P04 Appraisal rate

Appraisal rate

Risk Rating: **High (Action)**

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

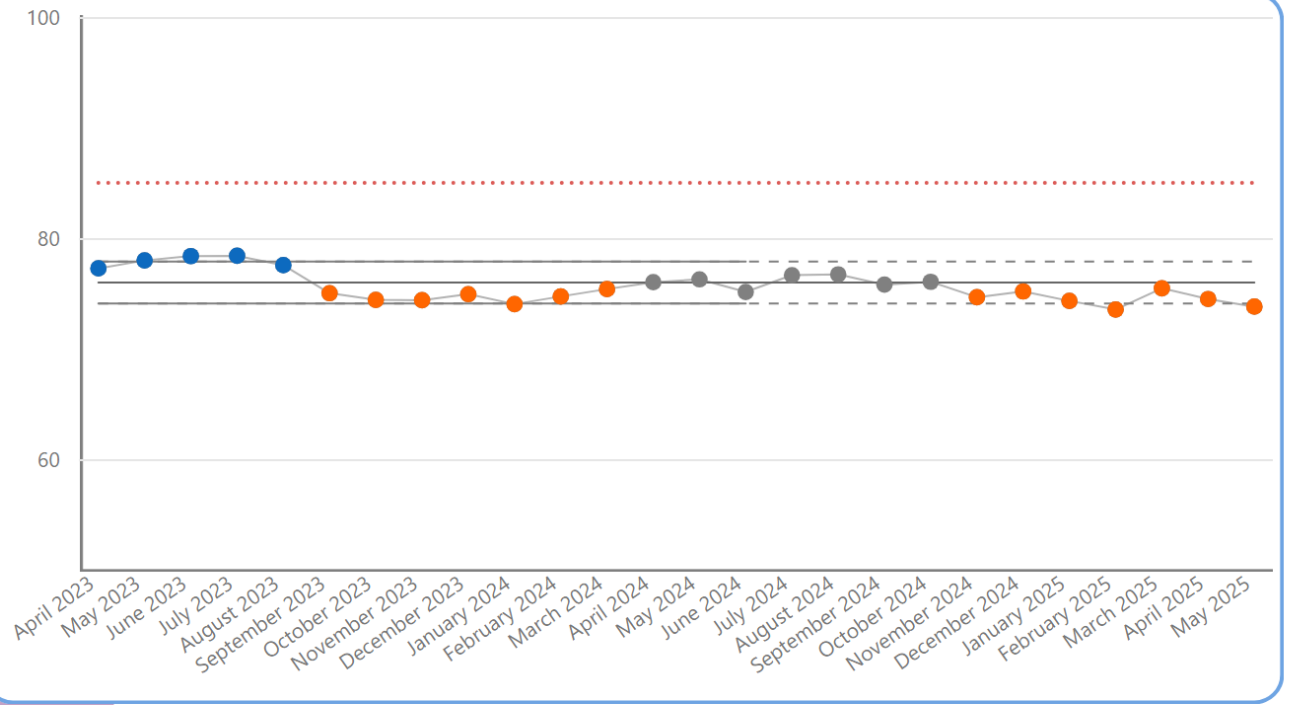
73.8%

tgt. 85%
n. 6,063
d. 8,215

Concern
There is concern because this indicator is decreasing

Consistently Off Target
The target for this indicator is outside 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	77.8%	2,628	3,380	85%		Normal Variation		Consistently Off Target
Inpatient Care Group	74.1%	1,295	1,748	85%		Normal Variation		Consistently Off Target
Specialist Care Group	70.6%	1,369	1,940	85%		Concern		Consistently Off Target
Support & Corporate	67.2%	771	1,147	85%		Concern		Consistently Off Target

Feedback

What the chart tells us

The reported appraisal rate for May is 73.8% which is a decrease from April (74.5%) (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

Improvement Actions

- Detailed information provided at Business Development Group – Workforce (BDGW) regarding appraisal rates and follow up discussion planned
- Groups to review those under 50% compliance and provide plans for improvement into BDGW in June 2025
- Corporate appraisal rates shared with Executive Director

Expected impact and by when

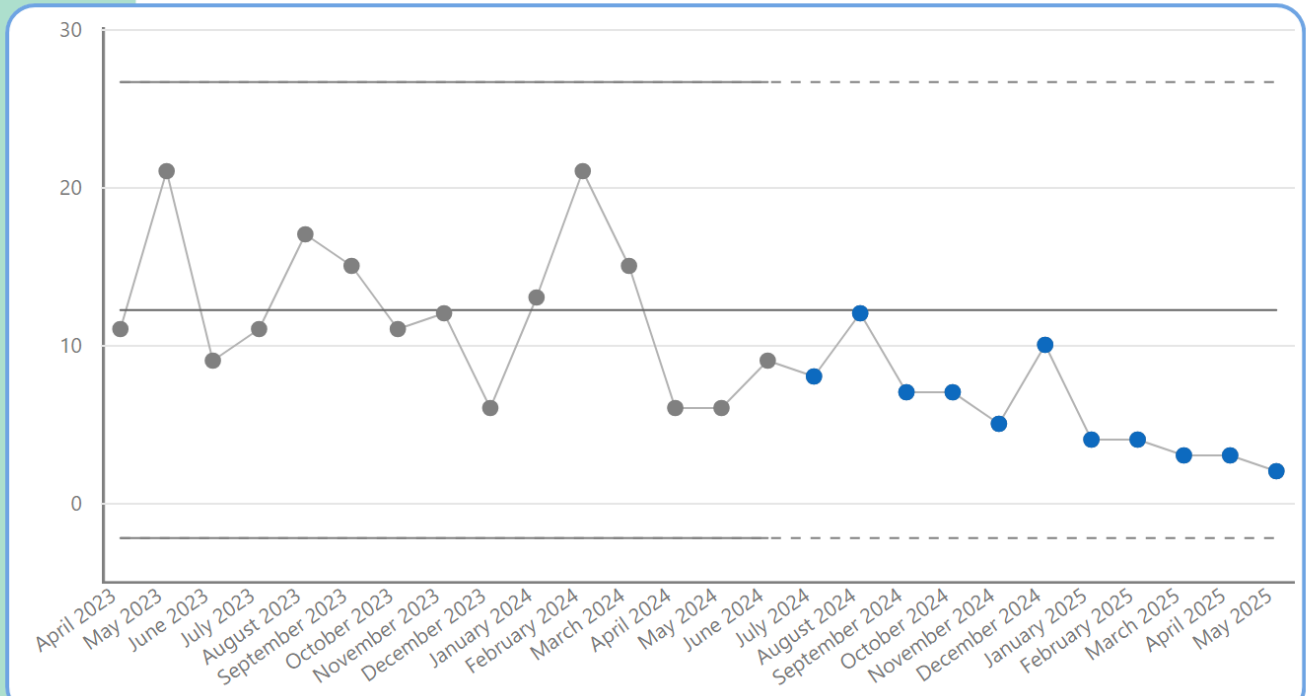
- Appraisal compliance is expected to increase over 2025/26 in line with improvement plans.

Q01 MRE Restraints

Number of MRE Restraints

Risk Rating: Med (Monitoring)

2	Improvement	SPC not applicable	DQ - No Concern
	This indicator is decreasing which shows improvement	Assurance cannot be given as there is no target and/or process limits	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 not applicable
Inpatient Care Group	1	n/a	Improvement	SPC not applicable
Specialist Care Group	1	n/a	Normal Variation	SPC not applicable
Support & Corporate	0	n/a	Normal Variation	SPC not applicable

Feedback

What the chart tells us

There were 2 MRE restraints relating to 2 individuals, reported in May 2025. within two wards Stephenson CYPS (1) and Shoredrift (1).

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 most frequent use of MRE within mainstream ward's is in relation to the transfer and return of patients to our local Acute Hospitals to support with physical health interventions. Anecdotal feedback suggests that the approval of MRE does not always result in it being used.

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
- Autism inpatients also report via CQC assurance; incidents of restraint, learning from ELR etc are shared with care group and discussed at safety meetings. Generally, use of restraint has fallen This highlights that other tools (use of safety pods etc) are having positive impact.
- 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. There is focused work during Quarter 1 to have all wards achieving compliance.
- Focus on HOPEs awareness training.
- Build in review process for each use with the approving Director.
- Revised Inpatient Care Group RRI ambitions for 25/26 developed (awaiting approval). The Group's RRI meeting continues to have oversight of progress.
- Introduction of EMDT will enrich the therapeutic environments increasing safety, recovery and wellbeing of patients and staff.
- Linking in with other Trusts in relation to understand their restrictive intervention practice

Expected impact and by when

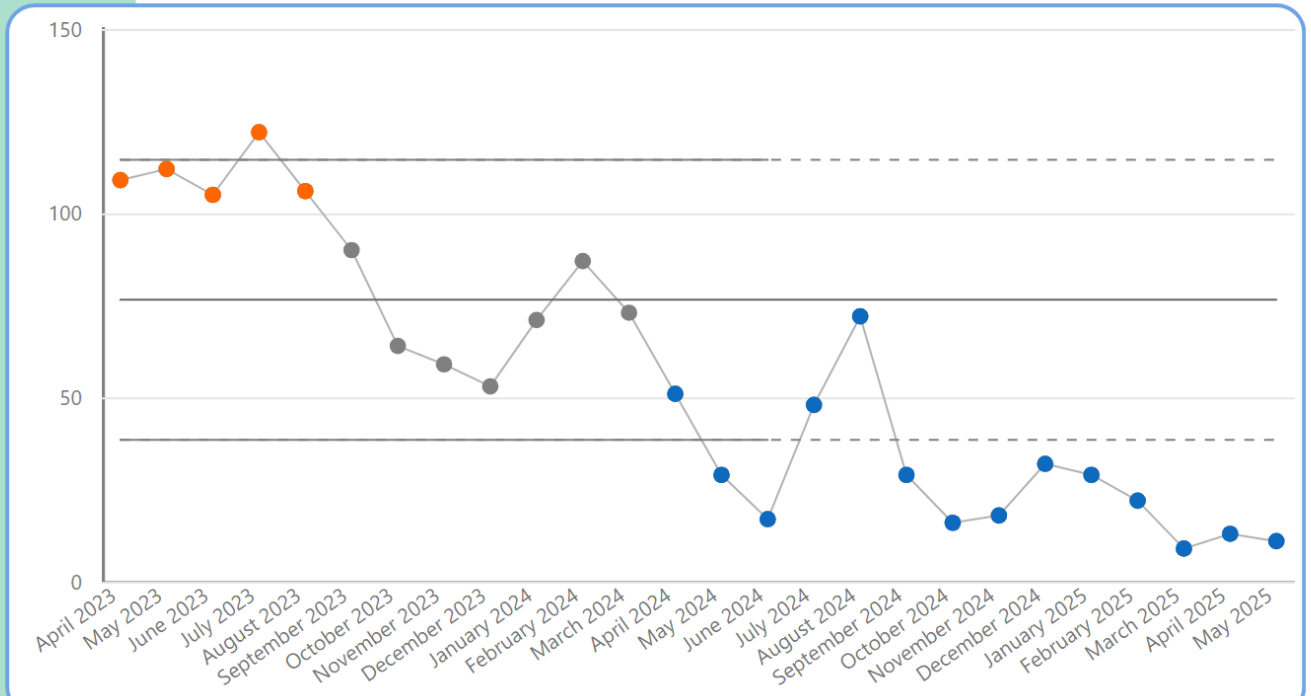
Continued reduction throughout 25/26, further specific actions within Care Groups will support reductions and delivery in line with agreed ambitions.

Q02 Prone Restraints

Number of Prone Restraints

Risk Rating: Med (Monitoring)

11	Improvement	SPC not applicable	DQ - No Concern
	This indicator is decreasing which shows improvement	Assurance cannot be given as there is no target and/or process limits	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 not applicable
Inpatient Care Group	2	n/a	Improvement	SPC not applicable
Specialist Care Group	9	n/a	Improvement	SPC not applicable
Support & Corporate	0	n/a	Normal Variation	SPC not applicable

Feedback

What the chart tells us

There have been 11 Prone restraints reported in May 2025, which is a decrease from 13 incidents reported in April 2025. Two separate wards - Mitford (8) and Stephenson (1), accounted for 81.8% (9) of the incidents and 18.2% (2) within the inpatient care group (Alnmouth and Rose Lodge). It should also be noted that Central and North Cumbria wards have reported no episodes of prone restraint.

Root Cause of the performance issue

- Low levels of prone usage in month with 2 incidents reported. The Trust's PICU (Beckfield) continues to report the highest use of Prone. Prone use is often related to seclusion exit and the administration of medication.

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
- A Biopsychosocial Team Formulation Workshop has taken place, alongside discussion with family and a functional assessment of behaviour that challenges. The focus has been to review and establish a consistent daily structure that keeps him engaged in predictable activities that functionally replace behaviour that challenges.
- Safeguarding plans/care planning in place (CYPS) .
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- Focus on HOPEs awareness training
- Revised Inpatient Care Group RRI ambitions for 25/26 developed (awaiting approval). The Group's RRI meeting continues to have oversight of progress.
- PVMA tutors have shared alternative approaches in relation to medication administration and seclusion exit. A targeted approach will be adopted in relation to ensuring alternative strategies are embedded within wards where prone use is high.
- CBU local RRI meetings consider alternative strategies to reduce incidents.
- Escalate all episode of prone to debrief that includes senior clinicals and senior leadership (inform care planning and earlier non-restrictive interventions).
- All patient who are known to require restrictive interventions including restraint have trauma informed and individualised care plans in place for this.

Expected impact and by when

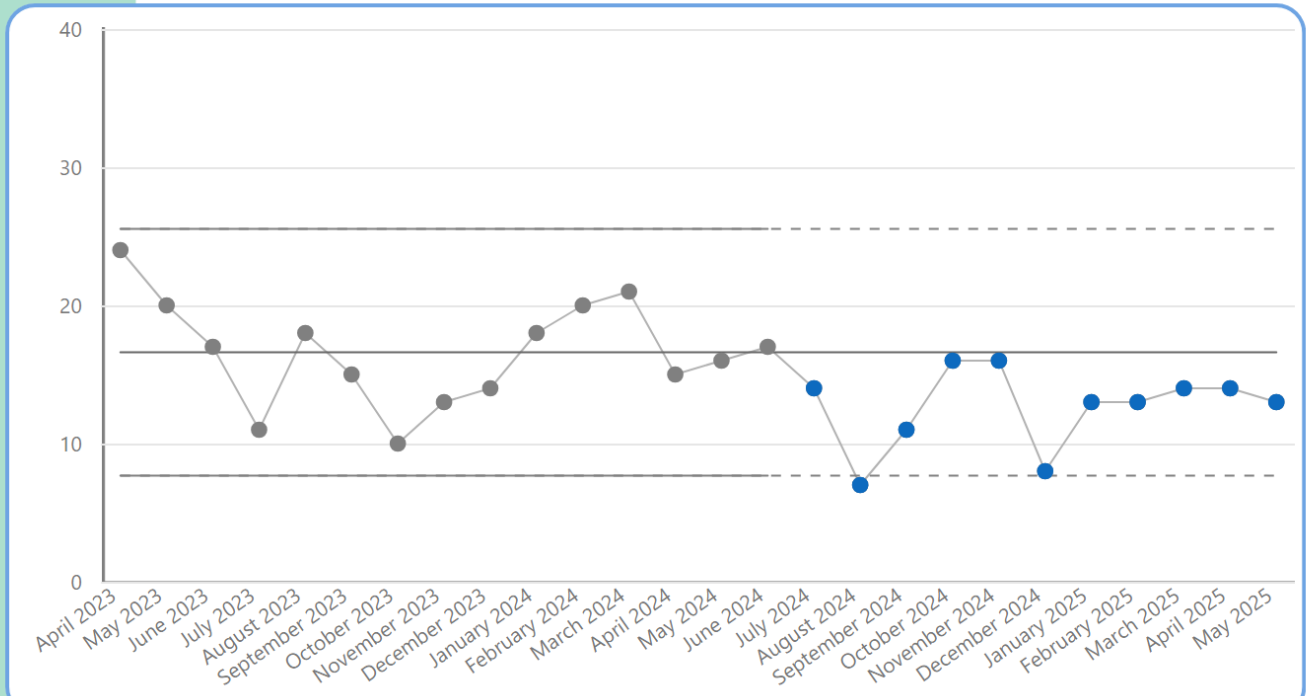
Delivery in line with agreed ambitions

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)

13	Improvement	SPC not applicable	DQ - No Concern
	This indicator is decreasing which shows improvement	Assurance cannot be given as there is no target and/or process limits	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 not applicable
Inpatient Care Group	13	n/a	Normal Variation	SPC not applicable
Specialist Care Group	0	n/a	Improvement	SPC not applicable
Support & Corporate	0	n/a	Normal Variation	SPC not applicable

Feedback

What the chart tells us

There were 13 incidents relating to 13 patients reported in May 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.
- The Care Groups continue to contribute and attend LTS panels
- LTS is 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 3 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.
- Considering methodology to support the reduction of seclusion incidents and to align the number seclusion suites.
- 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. The Group are involved in discussions in relation to the appropriate number of seclusion facilities across inpatient sites.

Expected impact and by when

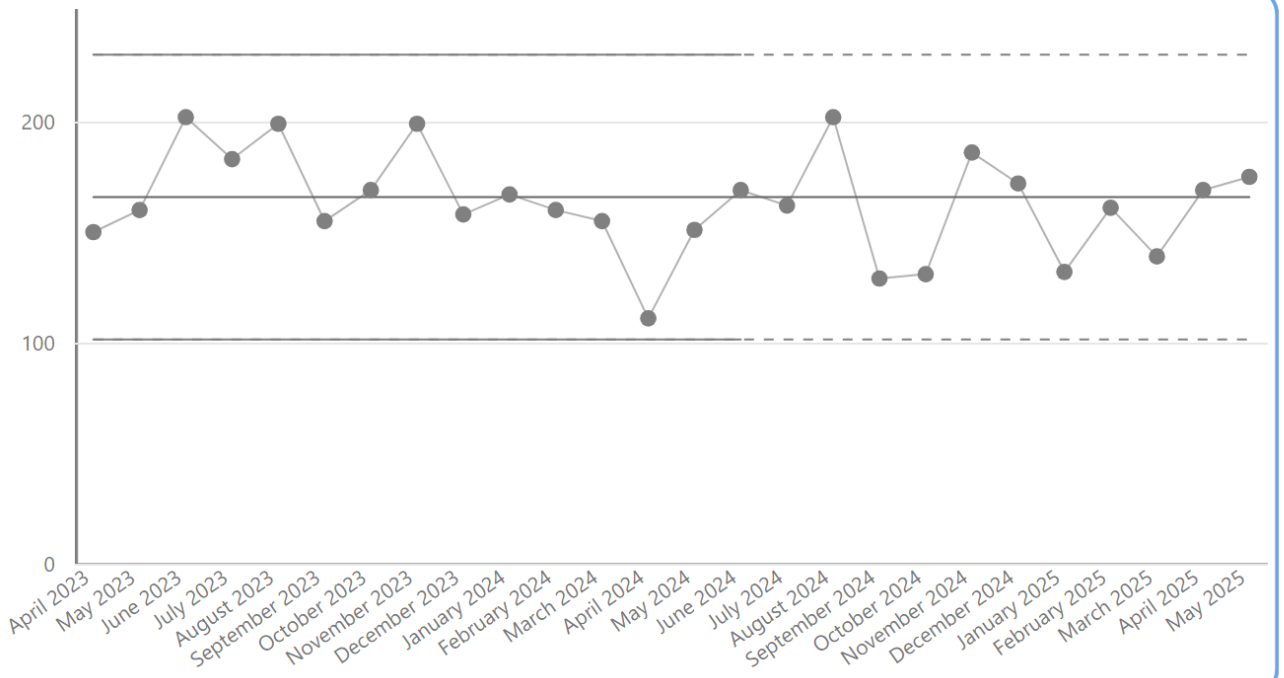
The system blocks remain outside CNTWs control therefore the Trust is dependent upon availability of specialised placements being made available/ built for those patients who require these placements.

Q04 Assaults on Patients

Number of Assaults on Patients

Risk Rating: Med (Monitoring)

175	Normal Variation	SPC not applicable	DQ - No Concern
	The variation for this indicator is within the control limits	Assurance cannot be given as there is no target and/or process limits	There are currently no concerns with the data quality of this indicator



Care Group	Performance	Target	Variation	Assurance
Community Care Group	18	n/a	Concern	SPC not applicable
Inpatient Care Group	132	n/a	Normal Variation	SPC not applicable
Specialist Care Group	25	n/a	Normal Variation	SPC not applicable
Support & Corporate	0	n/a	Normal Variation	SPC not applicable

Feedback

What the chart tells us

There were 175 recorded incidents of assaults on patients during May.

Root Cause of the performance issue

- Of the 175 assaults in May 2025, 54.3% of the assaults involved no physical harm and 44.6% resulted in low physical harm and 1.1% (1) resulted in moderate physical harm. There were no incidents reported as severe physical harm.
- Patient on patient violence and aggression continues to feature across our services, with an increase incidents in month. Patient safety and patients feeling safe remains a priority for the trust. The number of patient on patient assaults continues to be higher in the urgent care pathway (60% of the activity in May). All incidents in month were either no or low harm.

Improvement Actions

- Patient on patient assaults remains an area of focus as part of the Reducing Restrictive Interventions and Violence work.
- Regular review of care plans (identification of cause and strategy) and consideration of other environmental factors and care delivery approaches takes place by the MDT.
- Since debrief policy ratification teams have received debrief training and reviewed process to ensure patients and staff have the opportunities for debriefs. Debrief should enable greater understanding of and formulation of incidents to reduce further incidents of violence.
- Enhanced engagement for repeat perpetrator.
- Safeguarding Adult LA referral dependant on the severity of the incident.
- Review of patient mix if incidents are ongoing.
- Introduction of EMDT will enrich the therapeutic environments increasing safety, recovery and wellbeing of patients and staff.

Expected impact and by when

During 2025/26 the Trust aims to reduce the levels of violence and aggression. Several of the Trust's Quality Priorities for 2025/26 will support the delivery of this which will be monitored via Trust governance.

Q05 Assaults on staff

Number of Assaults on staff

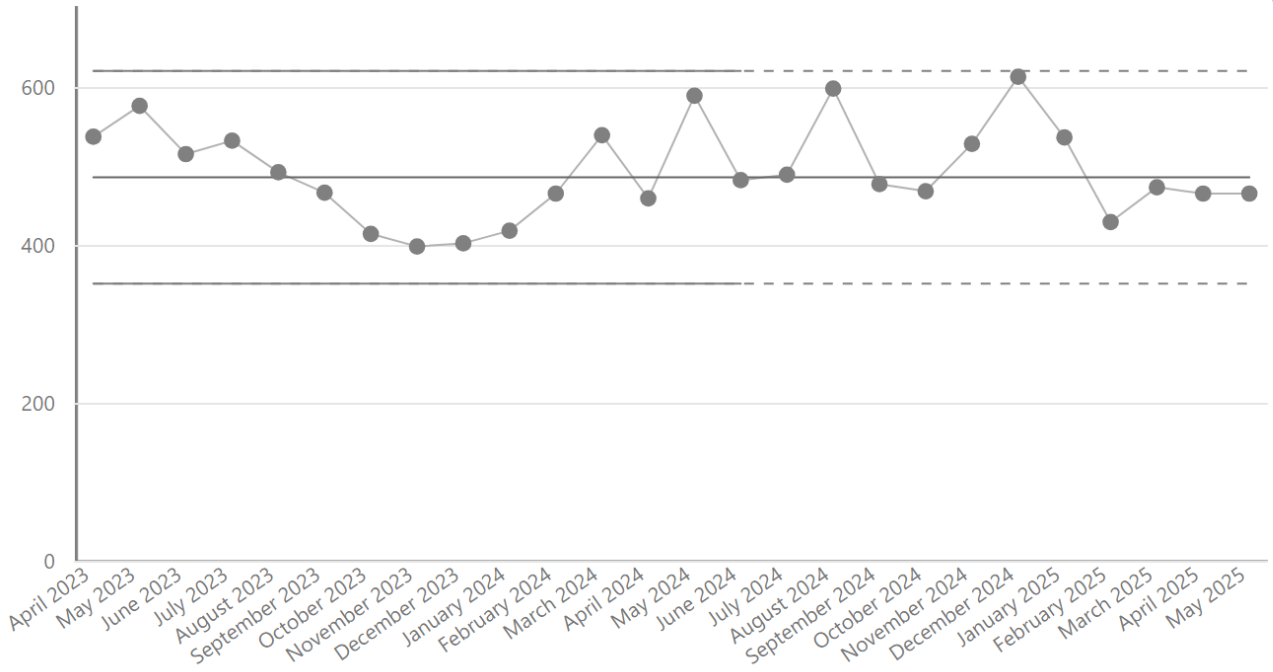
Risk Rating: Med (Monitoring)

465

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

SPC not applicable
Assurance cannot be given as there is no target and/or process 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	8	n/a	Concern	SPC not applicable
Inpatient Care Group	216	n/a	Normal Variation	SPC not applicable
Specialist Care Group	241	n/a	Normal Variation	SPC not applicable
Support & Corporate	0	n/a	Improvement	SPC not applicable

Feedback

What the chart tells us

There were 465 recorded incidents of assaults on staff during May

Root Cause of the performance issue.

- Of the 465 assaults, 47.5% of the harm were reported as no harm, 50.8% are low harm this is comparable with the previous month with an increase of 0.6% in no harm incidents. There has been a 1.0% decrease in low harm incidents from April 2025. 1.7% (8) are reported as moderate harm.
- RIDDOR incidents relating to aggression and violence or injured during restraint were reported as 10 for the month in comparison to 6 for April
- Violent incidents are potentially harmful and impact on staff and patient wellbeing, therefore continues to be an area of focus. Staff assaults in the urgent care and older people organic pathways continue to be problematic. Rose Lodge remains the most significant area of concern with the highest number of incidents in month. Assaults of staff are the highest cause of the Groups moderate physical harm incidents.

Improvement Actions

- This area continues to receive regular review in key management and governance groups, including the weekly safety where there is a focus on moderate or above harm incidents.
- Ward level risk assessments in place around violence and aggression per policy.
- Staff assaults remains an area of focus as part of the Reducing Restrictive Interventions and Violence work.
- Since debrief policy ratification teams have received debrief training and reviewed process to ensure patients and staff have the opportunities for debriefs. Debrief should enable greater understanding of and formulation of incidents to reduce further incidents of violence
- Staff side 'drop ins' and increased support and supervision offers to staff where needed.
- Promote access to Occupational Health to support staff wellbeing.
- High levels of focus are given to incidents that result in staff absence with an associated RIDDOR submission.
- Introduction of EMDT will enrich the therapeutic environments increasing safety, recovery and wellbeing of patients and staff.

Expected impact and by when

During 2025/26 the Trust aims to reduce the levels of violence and aggression. Several of the Trust's Quality Priorities for 2025/26 will support the delivery of this which will be monitored via Trust governance. A response is still awaited from the HSE around closure of the improvement notice.

Q06 % of patients with a Safety Plan

% of patients with a Safety Plan

Risk Rating: Med (Monitoring)

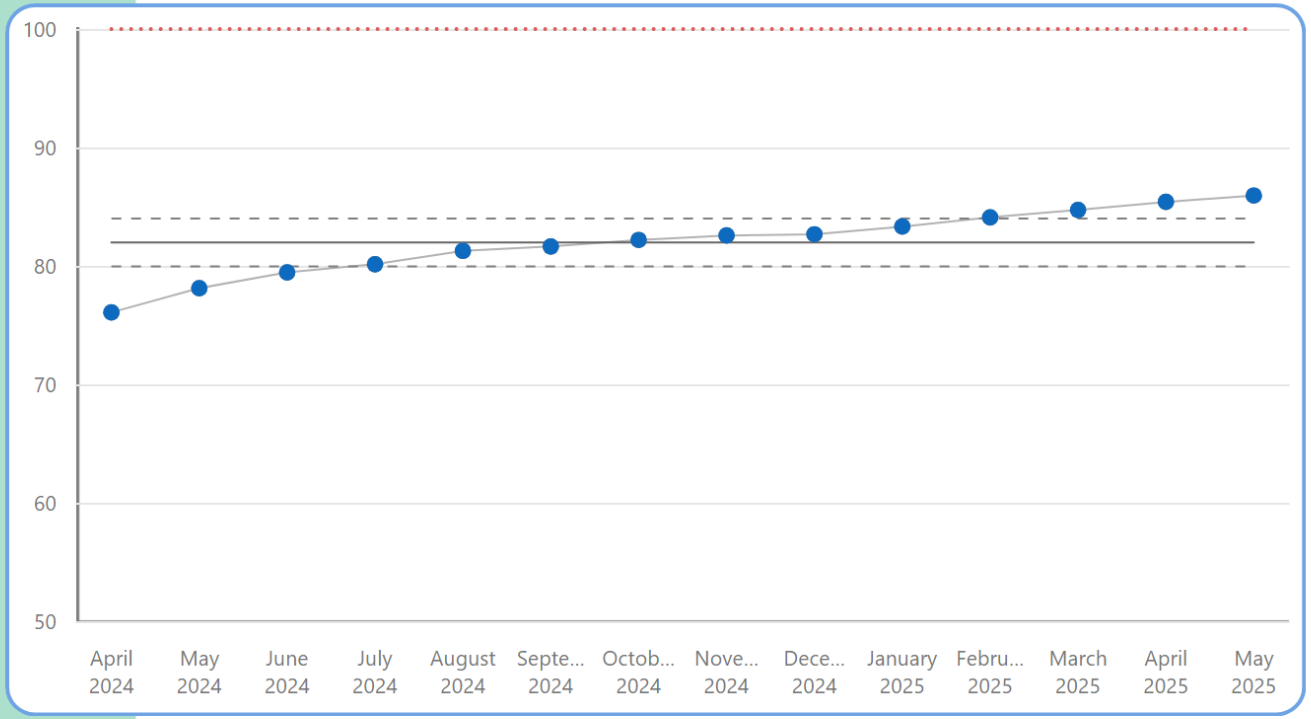
tgt. = target n. = numerator d. = denominator

85.9% tgt. 100% n. 32,568 d. 37,895

Improvement
This indicator is increasing which shows improvement

Consistently Off Target
The target for this indicator is outside 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	84.5%	24,793	29,337	100%	Improvement	Consistently Off Target
Inpatient Care Group	99.3%	728	733	100%	Improvement	Consistently Off Target
Specialist Care Group	89.8%	6,848	7,624	100%	Improvement	Consistently Off Target
Support & Corporate	99.0%	199	201	100%	Improvement	Achieve at Random

Feedback

What the chart tells us

In May 85.9% 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

- A framework for evaluating the quality of risk assessments and safety plans has been devised internally (based on NICE/NCISH metrics).
- Evaluation undertaken to date by the biopsychosocial risk assessment steering group highlights that staff do not always understand the difference between a risk management plan and a safety plan.
- Evaluation has now been devolved to the 3 groups in order that the oversight for quality of risk assessments/safety plans is integrated into weekly governance (Improvement) meetings. This allows for learning and group action plans to be formulated. A continuous quality improvement process is proposed, whereby the groups have nominated leads to audit the quality of risk assessments and safety plans.
- Enhanced staff training, specific to various services and patient presentations, has been developed. Videos are being developed by staff, people with lived experience and CNTW Academy and a growing repository will be housed on the trust intranet.
- External evaluation of the quality of risk assessments and safety plans is currently being undertaken by NICHE patient safety, an independent organisation. The evaluation comprises a table top review of risk assessments/safety plans (using CNTW metrics), staff, patient and carer interviews. Results of findings and recommendations to improve the quality of risk assessments and safety plans are due in September 2025.
- The biopsychosocial risk framework and safety planning policy is available to staff on the intranet
- 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

Improving the quality of risk assessments and safety plans is an ongoing quality aim for the trust.

Q07 Reducing incidents of self-harm

Number of incidents of self-harm

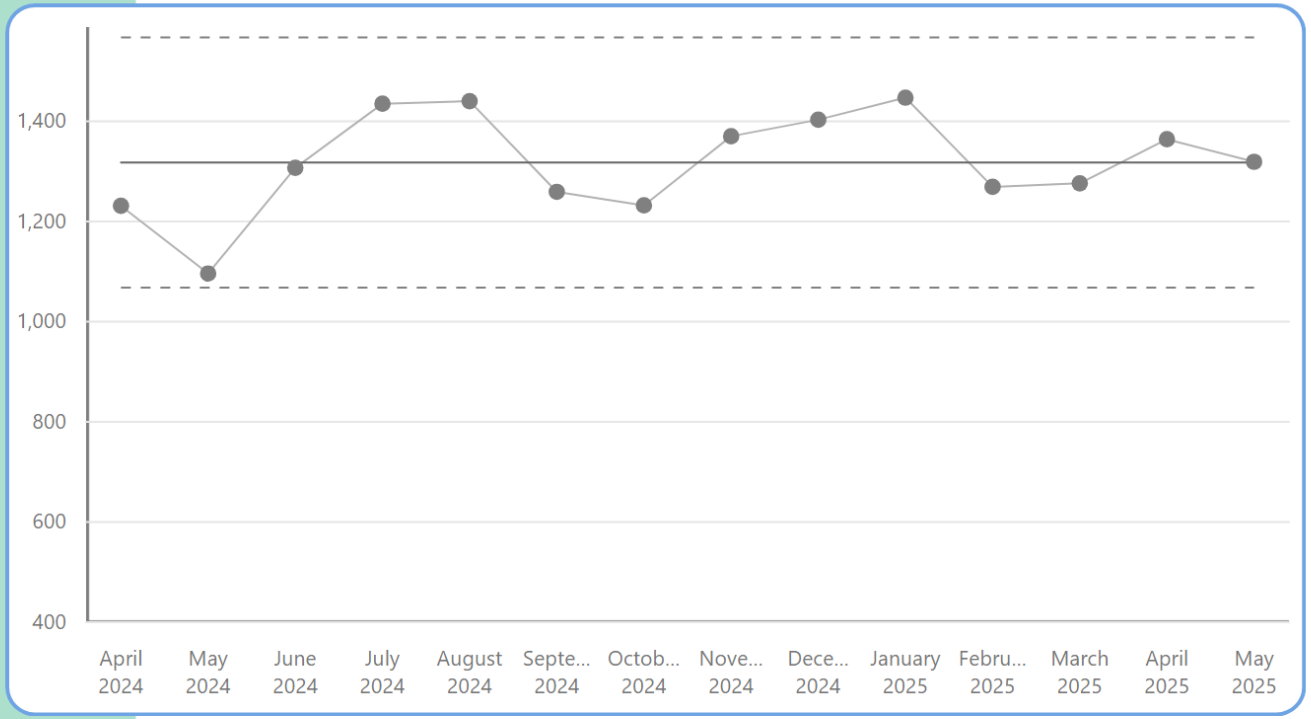
Risk Rating: Med (Monitoring)

1,317

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

SPC not applicable
Assurance cannot be given as there is no target and/or process 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	665	n/a	Normal Variation	SPC not applicable
Inpatient Care Group	336	n/a	Normal Variation	SPC not applicable
Specialist Care Group	316	n/a	Normal Variation	SPC not applicable
Support & Corporate	0	n/a	Normal Variation	SPC not applicable

Feedback

What the chart tells us

In May there was a decrease of incidents of self-harm from 1,362 in April to 1,317 in May.

Root Cause of the performance issue

- Figures in CYPS remain high across a range of services, this has links to those who are CRFD
- There are particularly high levels of self-harm in our female facilities within the acute pathway (85% of activity in month in female wards; ratio of female to male wards 1:2). Alnmouth and Lamesley report high levels of self-harm in month

Improvement Actions

- Mitford; part of CQC action plan and reviewed post incident and audited. A full table is available for overview of all incidents with harm. Actions taken and reviewed by team.
- Care groups review their self-harm incident data and outline governance processes and assurance to reduce self-harm incidents in their services using evidence-based interventions
- Self harm workshop on 7th May with care groups (operational and clinical staff) & corporate services to identify 3 SMART priorities, what needs to be done to achieve them.
- Evaluation metrics (based on NICE quality standards 34 & 189 , the NCISH toolkit and other evidence-based research) have been proposed and are in the process of being discussed at TSG and BDG-Q. 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) are now being uploaded on the trust intranet
- Management of self-harm is individualised, and care planned for each person based on formulation and reviewed as required and is individualised.
- Following incidents debriefs there is shared learning across the inpatient care group.
- Monitor quality of biopsychosocial risk assessments with safety planning on inpatient wards.
- Established Trustwide Self-Harm Steering Group and development of a new self-harm policy Oxehealth is alerting staff of self-harm incidents which potentially mitigates 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. It has been identified that reduction in incidents of self harm and suicide, and their impact, is an ongoing trust quality goal.

Q08 Rights at Point of Detention

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

Risk Rating: **Med (Monitoring)**

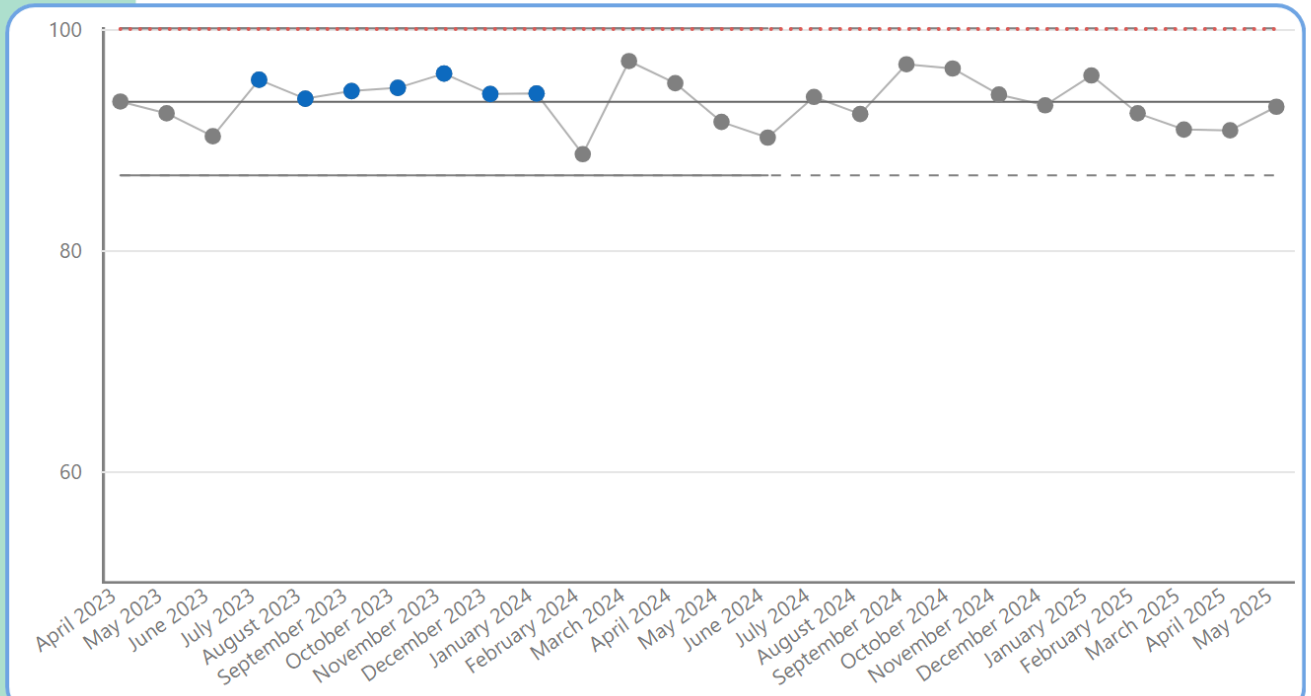
tgt. = target n. = numerator d. = denominator

93.0%	tgt.	100%
	n.	119
	d.	128

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

Achieve at Random
The target for this indicator is within the upper and lower 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	92.0%	104	113	100%	Normal Variation	Achieve at Random
Specialist Care Group	100.0%	15	15	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Compliance in this area continues to fluctuate and is reported for May at 93.0%. Without change, performance will remain consistently off target.

Root Cause of the performance issue

- Significant number of pertinent requirements to be completed at the point of admission.
- 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

- MHLT to prompt nursing staff to complete H3L (record of rights form at point of detention)
- 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.
- MHL specialist participates in CQC mock visits and reviews compliance with feedback
- 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 Training to focus on section 132 ensuring 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) to monitor performance.
- Continued awareness raising in relation to supporting material including rights on a page poster (outlines key duties in relation to the reading of rights).
- Continued focus on compliance position in care group governance meetings and within team brief.
- Automated weekly report to highlight non-compliance being set up

Expected impact and by when

Expected improvement during Q2 as a result of additional supportive mechanisms.

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)**

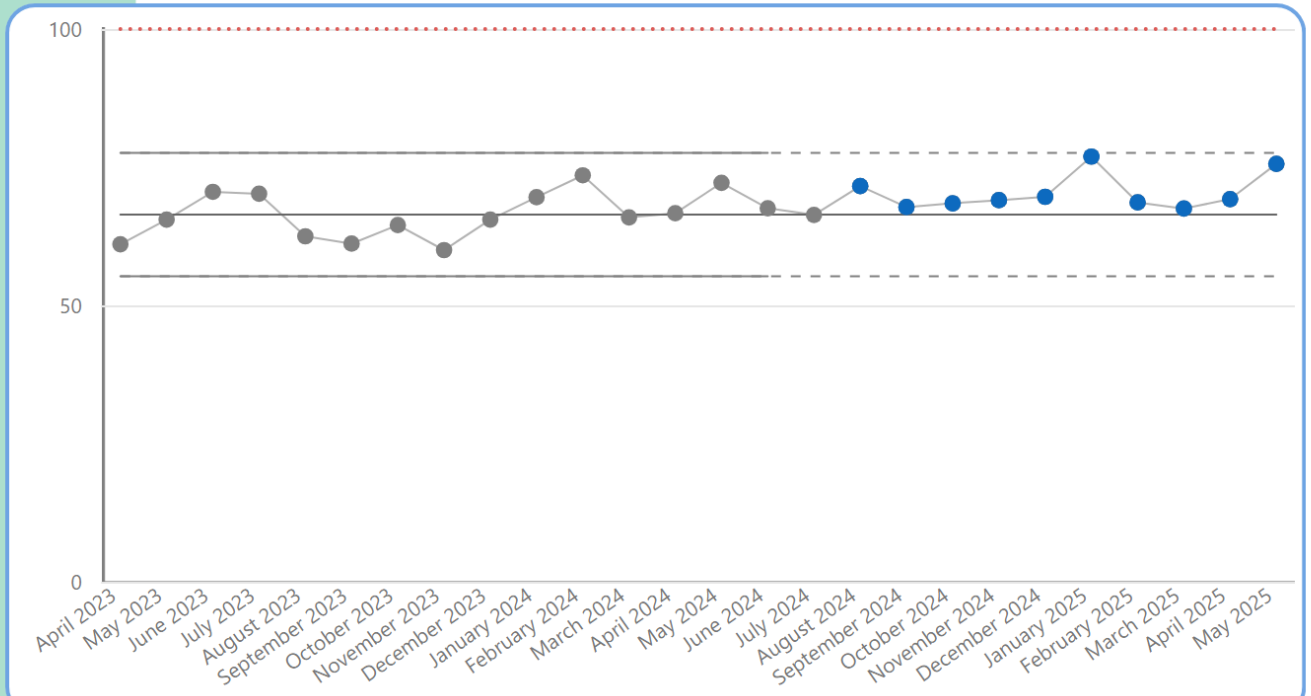
tgt. = target n. = numerator d. = denominator

75.6%	tgt.	100%
	n.	93
	d.	123

Improvement
This indicator is increasing which shows improvement

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

DQ - Investigating
There have been data quality concerns raised with indicator



Care Group	Performance	N	D	Target	Variation	Assurance
Inpatient Care Group	75.5%	83	110	100%	Improvement	Consistently Off Target
Specialist Care Group	76.9%	10	13	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

May compliance is reported at 75.6% for the completion of the local form Part A Record of Capacity/CTT. Significant improvement is required across the Trust.

Root Cause of the performance issue

- Lack of awareness on the requirement to complete this form as this is a local form rather than legal requirement (the legal requirement is at 3 months).
- Significant number of pertinent and competing requirements at the point of admission

Improvement Actions

- The MHL department to issue reminders to the Responsible Clinician and clinical staff at point of detention and 3-month rule.
- The MHL team provide monthly reports to the Associate Medical Directors copied to the Group MD's to address non compliance with individuals.
- Compliance will be discussed in appraisals for Responsible Clinicians
- Compliance to be monitored at Trustwide safety every 4 weeks, until an improvement is seen.
- Trust MHL Specialist to attend Group Quality meetings and participate in CQC mock visits
- A refinement of the part A and B forms in the EPR
- The MHLSG to consider and agree the recommendation to
    - exclude data where patients are transferred into the Trust as the responsibility would have been the previous detaining authority
    - exclude data or patients who are not on medication
    - Run the metric from the date of admission opposed to section date (for specific sections i.e. 37/41)

Expected impact and by when

Expected improvement during Quarter 2 as a result of additional focus

A01 Active Inappropriate Out of Area Placements

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

Risk Rating: Med (Monitoring)

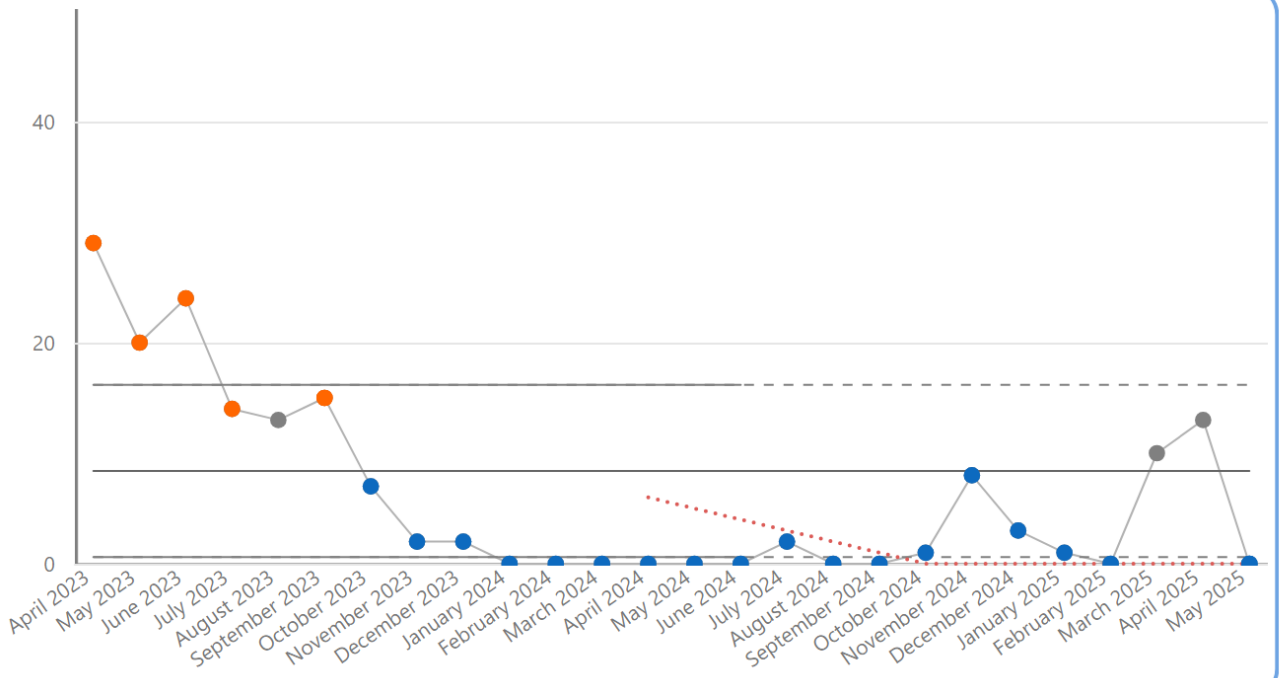
tgt. = target n. = numerator d. = denominator

0	tgt.	0
	n.	0
	d.	0

Improvement
This indicator is decreasing which shows improvement

Achieve at Random
The target for this indicator is within the upper and lower 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	0	0	0	0	Improvement	Consistently Off Target

Feedback

What the chart tells us

There were no active out of area placements reported as at 31st May 2025 within the adult acute pathway.

Root Cause of the performance issue

- High levels of demand for inpatient beds in all pathways.

Improvement Actions

- Enhanced bed management working closely with localities to support flow and repatriations.
- All daily flow meetings to be chaired by an Associate Director level member of staff.
- Development of a new patient flow model with a plan to implement in July 2025 (including a Hospital to Home team).
- Fidelity to the model has been restored and all formal mental health act assessments in the emergency department are undertaken by the Crisis Team.
- The group continue to be cognisant of bed pressure and OAPs in the context of the considered bed stock changes.

Expected impact and by when

The above actions will maintain the improved position and support the Trust trajectory of 0 OAPs

A02 Bed Occupancy including leave (open beds on RiO)

Bed Occupancy including leave (open beds on RiO)

Risk Rating: High (Action)

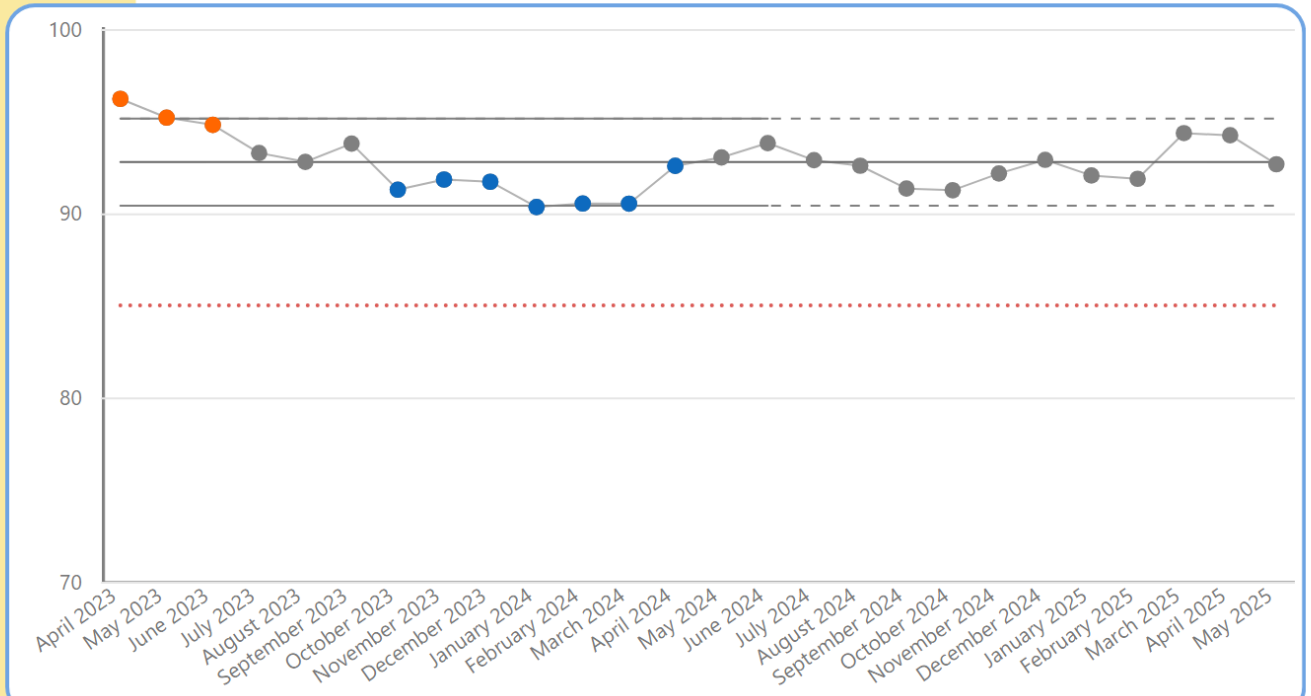
tgt. = target n. = numerator d. = denominator

92.7% tgt. 85% n. 21,294 d. 22,981

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

Consistently Off Target
The target for this indicator is outside 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	101.1%	15,057	14,890	85%	Normal Variation	Consistently Off Target
Specialist Care Group	77.1%	6,237	8,091	85%	Improvement	Achieve at Random

Feedback

What the chart tells us

Bed occupancy was reported at 92.7% in May, 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.
- The Trust is marginally above the lower quartile for acute beds per 100,000 resident population based on benchmarking data (2023/24).

Improvement Actions

- Enhanced Bed Management discharge facilitators support wards and are attached to each locality for consistency.
- 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 being developed for a learning disability outreach and transitions team to provide highly specialist, learning disability advice and consultancy that can support good mainstream inpatient practice.

Expected impact and by when

Bed occupancy will remain above the optimum 85% occupancy. Actions are aimed at improving flow and LOS however it is unlikely to impact on bed occupancy due to bed numbers and demand.

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)

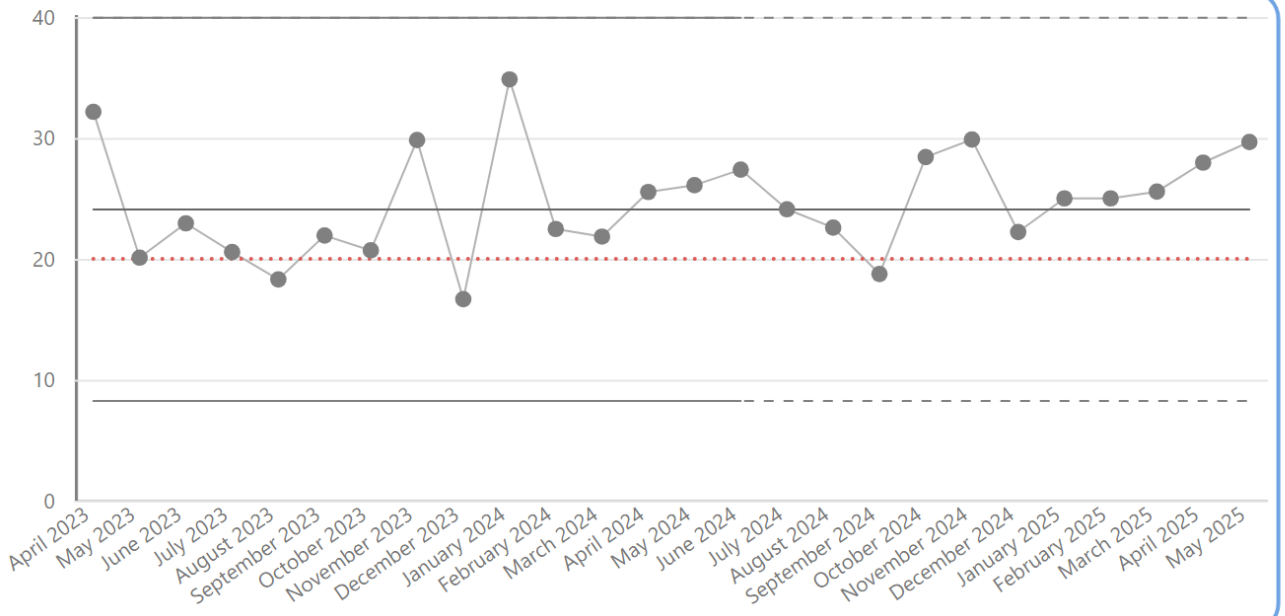
tgt. = target n. = numerator d. = denominator

29.7%		
	tgt.	20%
	n.	27
	d.	91

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

Achieve at Random
The target for this indicator is within the upper and lower 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	50.0%	8	16	20%	Concern	Achieve at Random
Neuro Rehabilitation & Specialist Services CBU	100.0%	1	1	20%	Normal Variation	Consistently Off Target
North Cumbria Inpatient CBU	26.1%	6	23	20%	Normal Variation	Achieve at Random
North Inpatient CBU	16.7%	4	24	20%	Normal Variation	Achieve at Random
South Inpatient CBU	29.6%	8	27	20%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In May 29.7% 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

- Prolonged period to achieve treatment optimisation due to complexity.
- Periods of leave to facilitate successful discharge into the community.
- Delayed discharges due to challenging and complex presentations and limited appropriate housing and or social support

Improvement Actions

- Focus on patient discharge from admission.
- Introduction of EMDT will enrich the therapeutic environments increasing safety, recovery and wellbeing of patients and staff.
- Development of a new patient flow model with a plan to implement in July 2025 (including a Hospital to Home team).
- Utilising of allocation held by EBM to support with overcoming barriers to discharge.
- Meetings are in place with the local authorities to review Clinically Ready for Discharges.
- Internal review of the MaRG meeting & the terms of reference take place based on learning to date.
- Draft service model being developed for a learning disability outreach and transitions team to provide highly specialist, learning disability advice and consultancy that can support good mainstream inpatient practice.

Expected impact and by when

Working to deliver LOS reductions in line with the agreed ICB trajectories.

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

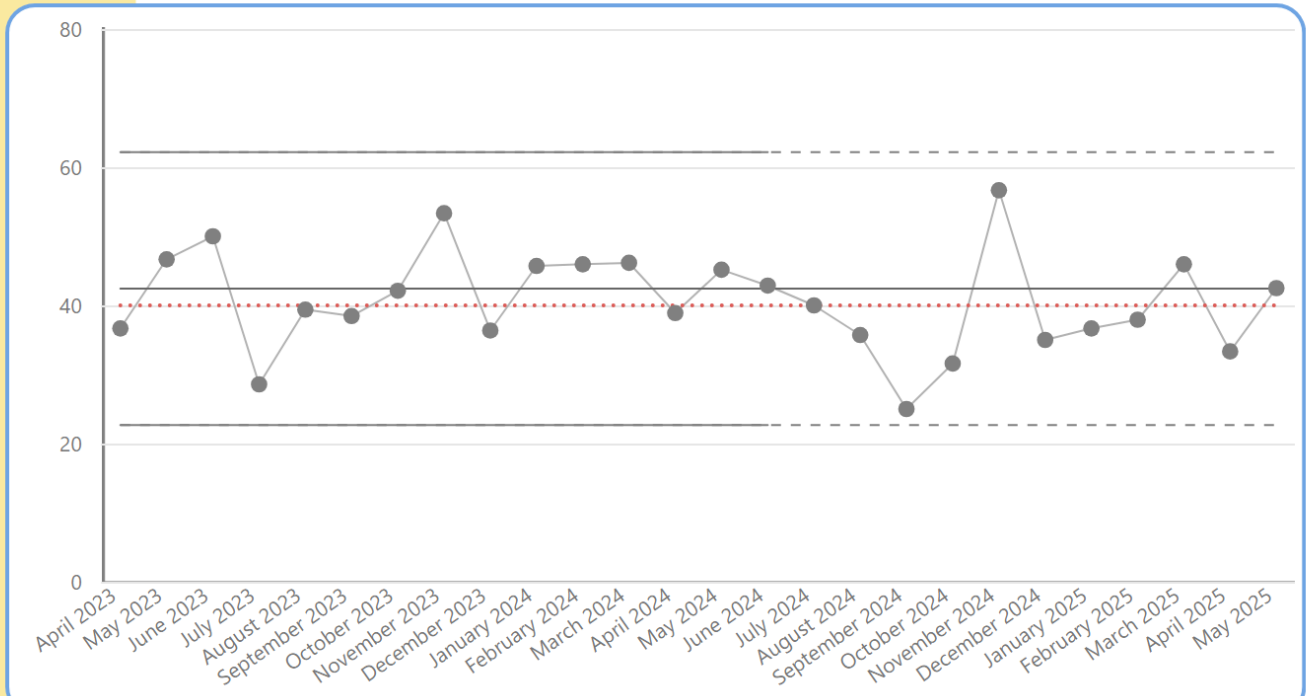
42.5%

tgt.	40%
n.	17
d.	40

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

Achieve at Random
The target for this indicator is within the upper and lower 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	33.3%	3	9	40%	Normal Variation	Achieve at Random
North Cumbria Inpatient CBU	37.5%	3	8	40%	Normal Variation	Achieve at Random
North Inpatient CBU	42.9%	3	7	40%	Normal Variation	Achieve at Random
South Inpatient CBU	50.0%	8	16	40%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In May 42.5% 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.
- 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.
- Introduction of EMDT will enrich the therapeutic environments increasing safety, recovery and wellbeing of patients and staff.
- Development of a new patient flow model with a plan to implement in July 2025 (including a Hospital to Home team).
- Utilising of allocation held by EBM to support with overcoming barriers to discharge.
- Meetings are in place with the local authorities to review Clinically Ready for Discharges.
- Internal review of the MaRG meeting & the terms of reference take place based on learning to date.
- 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

Working to deliver LOS reductions in line with the agreed ICB trajectories.

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)**

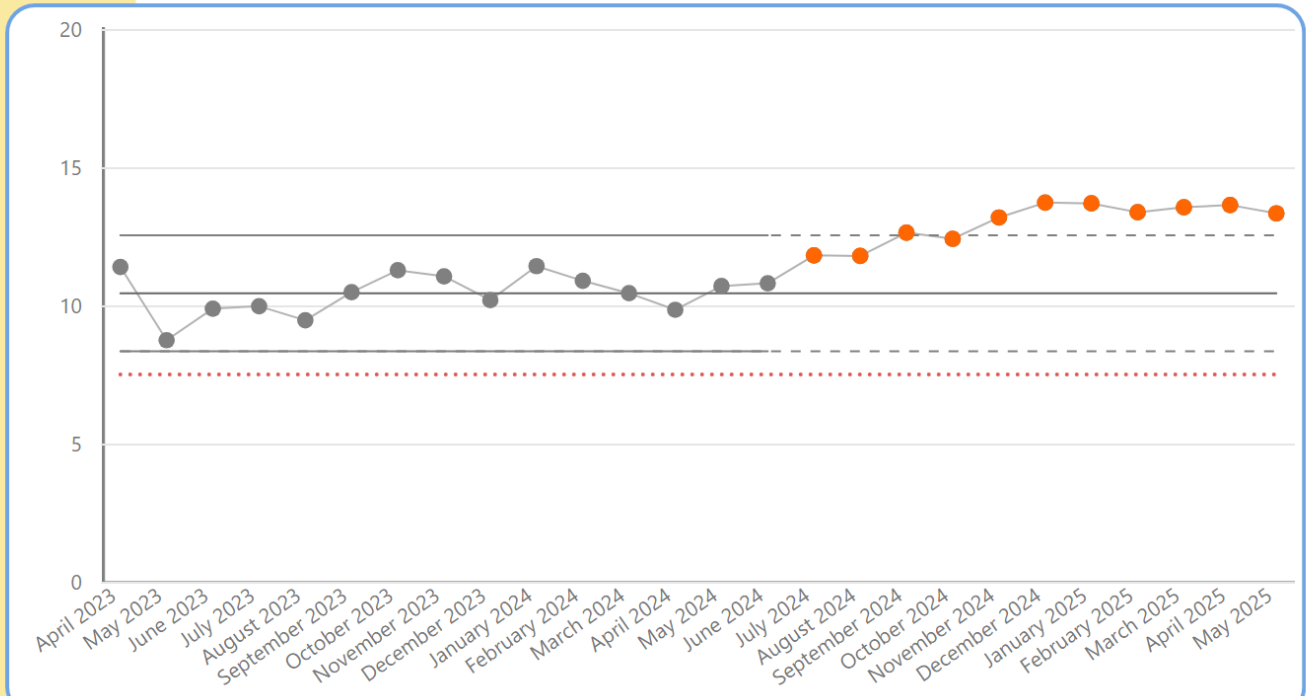
tgt. = target n. = numerator d. = denominator

13.3% tgt. 7.5% n. 2,453 d. 18,409

Concern
There is concern because this indicator is increasing

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

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



Pathway	Performance	N	D	Target	Variation	Assurance
Adult Acute and PICU	8.6%	609	7,067	7.5%	Normal Variation	Achieve at Random
Adult Rehabilitation	18.0%	783	4,352	7.5%	Concern	Achieve at Random
Learning Disability	49.5%	93	188	7.5%	Normal Variation	Consistently Off Target
Older Persons	18.8%	627	3,338	7.5%	Concern	Consistently Off Target
Other	9.8%	341	3,464	7.5%	Concern	Consistently Achieve

Feedback

What the chart tells us

In May 13.3% of patients were Clinically Ready for Discharge (CRFD). Within CYPS 16.6% of current patients (4) at 31.05.25 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. Highest proportions of CRFD bed days remain within the Rehab pathways. The highest % of CRFD bed days is in North Cumbria's Older Peoples pathway (29% of CRFD bed days).

Improvement Actions

- Within Specialist CYPS reports are available (via provider collaborative) to see CRFD rates
- Multi-agency Response Group (MaRG) incorporating local authorities, ICB and CNTW teams continues to be in place. Internal review of the MaRG meeting & the terms of reference take place based on learning to date.
- Engaged with Cumberland Local Authority in relation to robust intermediate care options/ models that would support the timely discharge of these individuals.
- Development of a new patient flow model with a plan to implement in July 2025 (including a Hospital to Home team).
- Utilising of allocation held by EBM to support with overcoming barriers to discharge.
- Engagement with the ICB in terms of our involvement in the ICB led 'Better homes and healthier lives Programme'.
- Place-based CRFD patient report circulated weekly to community directors for sharing with their respective teams to collectively support the discharge process.

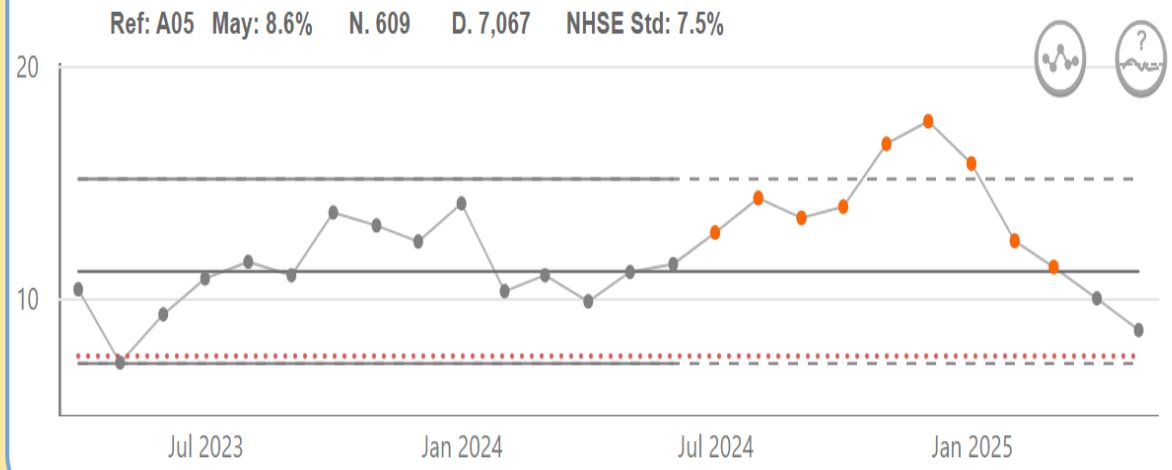
Expected impact and by when

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

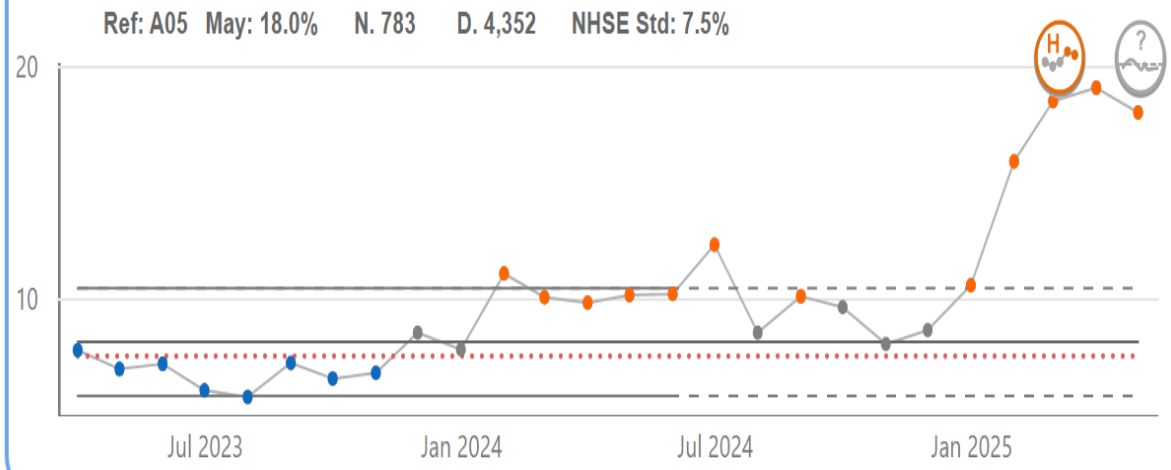
A05 Clinically Ready for Discharge (formerly DTOC)

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

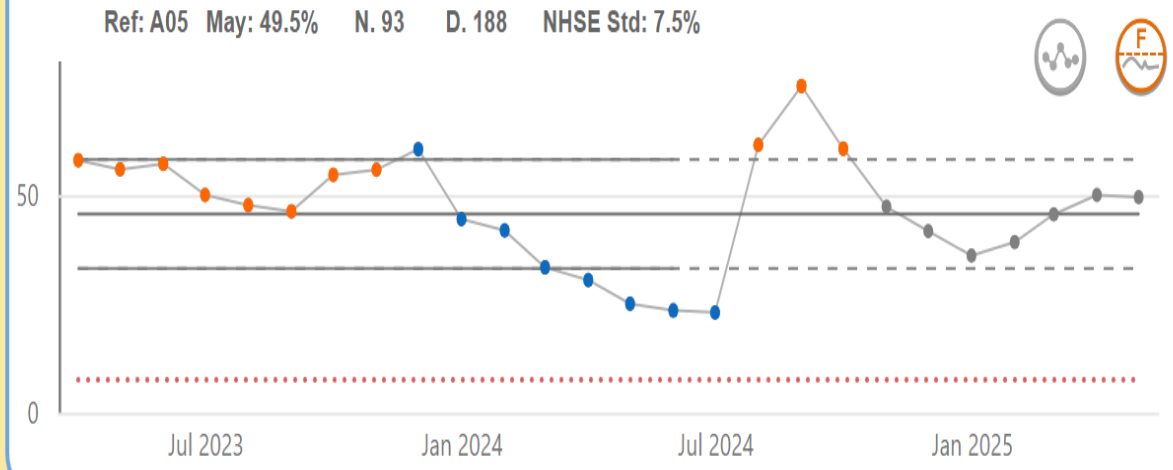
Adult Acute and PICU



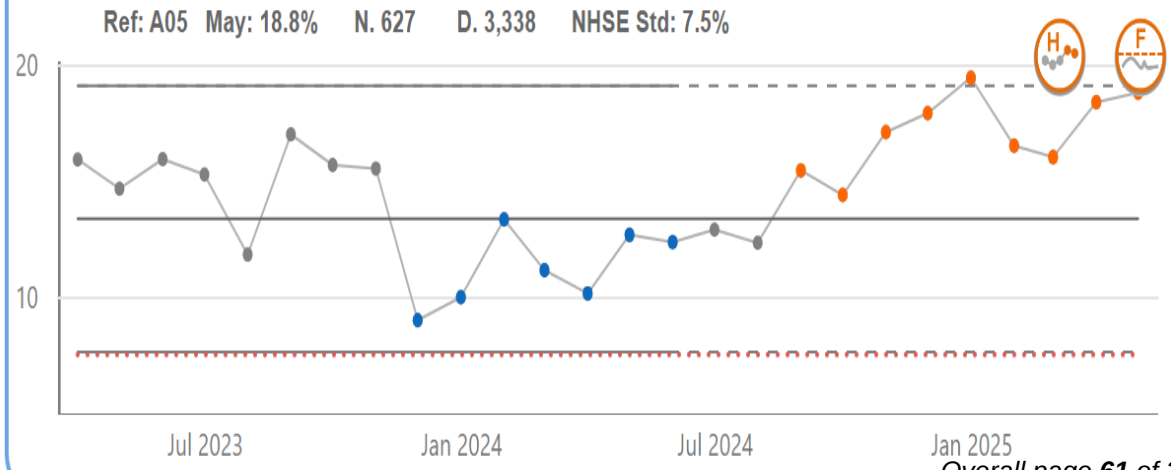
Adult Rehabilitation



Learning Disability



Older Persons



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: **Med (Monitoring)**

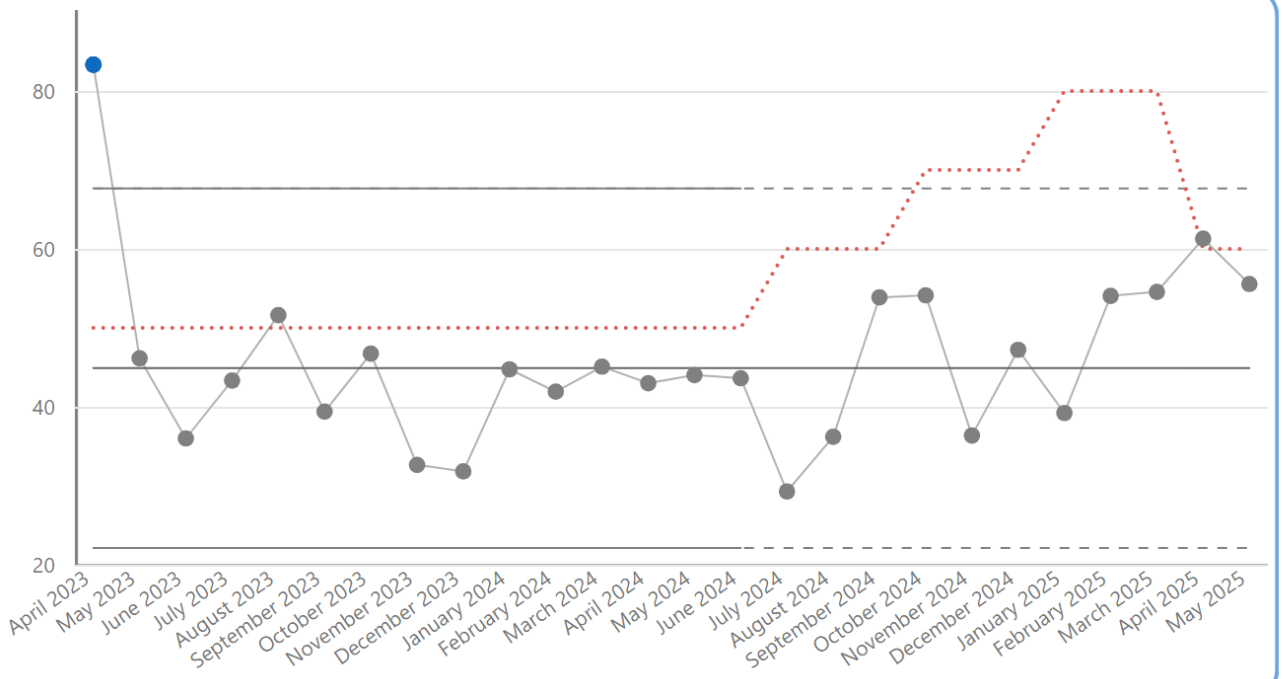
tgt. = target n. = numerator d. = denominator

55.6%	tgt.	60%
	n.	30
	d.	54

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

Achieve at Random
The target for this indicator is within the upper and lower 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	47.6%	10	21	60%	Normal Variation	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	66.7%	12	18	60%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	53.3%	8	15	60%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Very urgent referrals seen within 4 hours achieved 55.6%. The internal trajectory of 60% for Quarter 1 was agreed at Access Oversight Group and the chart has been updated to reflect the change from April 2025.

Root Cause of the performance issue

Performance has improved however:

- 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.
- Increase in violence and aggression in 136 suites impacting staff sickness in some teams.
- Some data quality/recording issues

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.

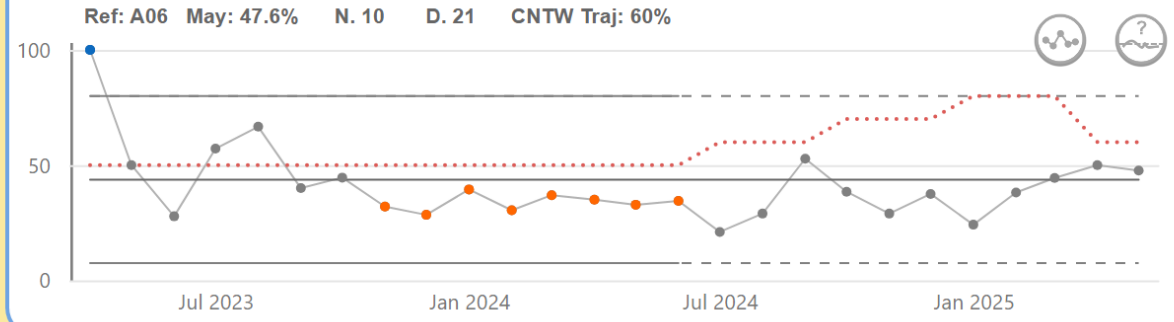
Expected impact and by when

Staffing remains an ongoing challenge with a reliance on agency staffing in places. It is anticipated that addressing staffing gaps will lead to a noticeable improvement in overall performance. The impact should keep the performance meeting trajectory for Q1 25/26.

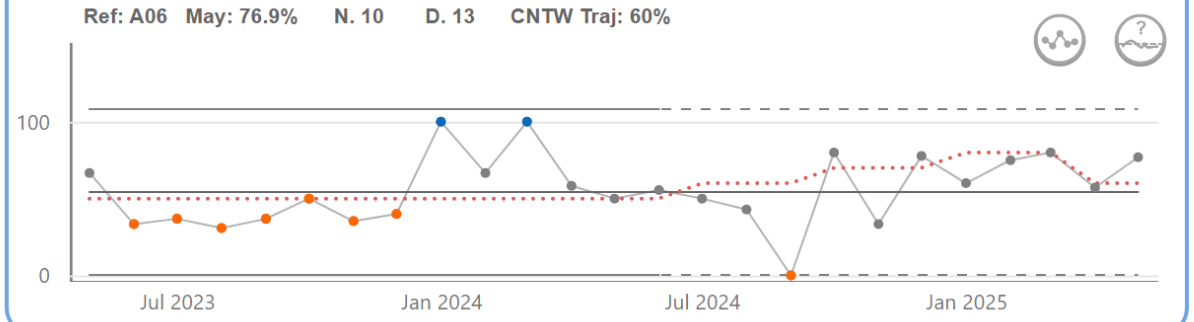
A06 Crisis % Very urgent seen within 4 hours (WAA&OP)

% 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

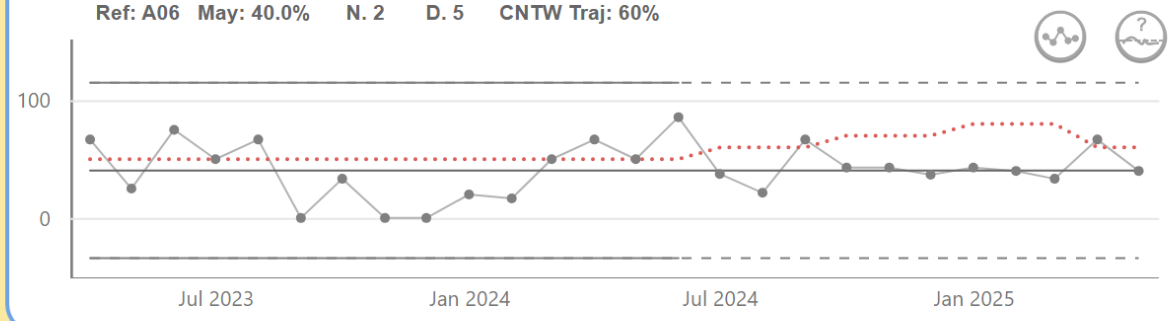
Newcastle & Gateshead Access CBU



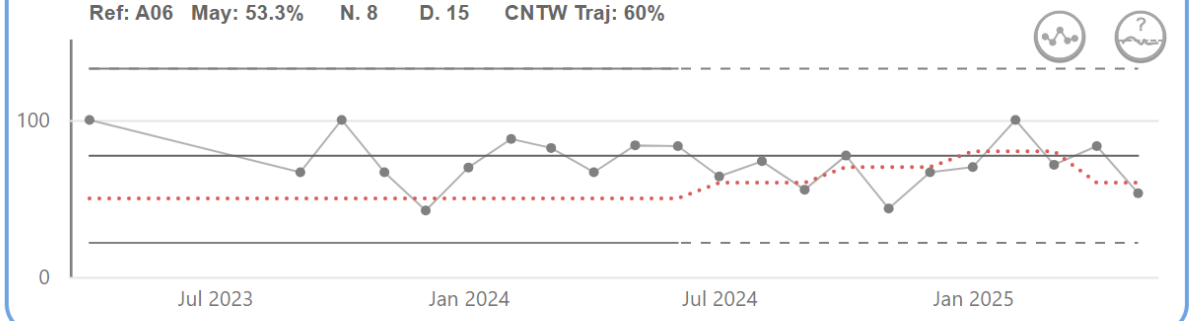
North Cumbria Community & Access CBU



Northumberland & North Tyneside Access CBU



Sunderland & South Tyneside Access CBU



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 44%. North Cumbria has an average performance of 77% with Sunderland and South Tyneside reporting around 53%, a significant deterioration compared to 83% in April. All areas saw a deterioration in performance except for North Cumbria which showed an improvement in May.

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 60% for the 4-hour response rate by March 2026.

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

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

Risk Rating: High (Action)

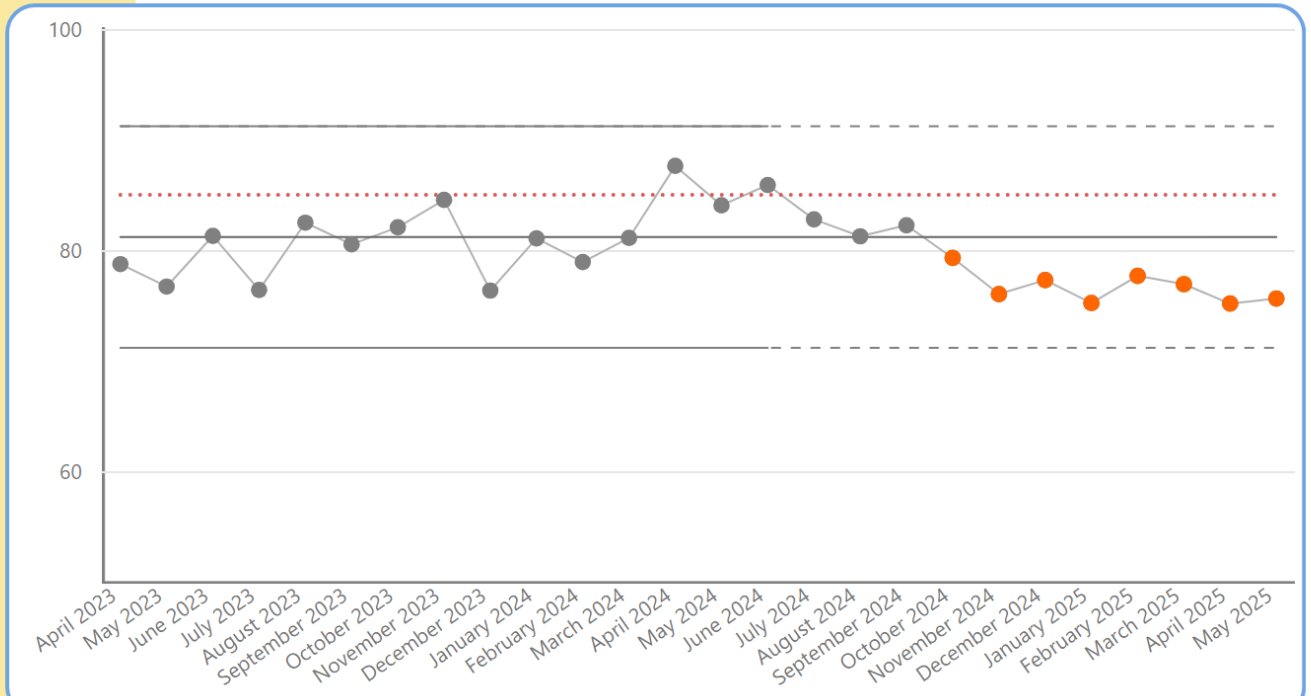
tgt. = target n. = numerator d. = denominator

75.6%	tgt.	85%
	n.	397
	d.	525

Concern
There is concern because this indicator is decreasing

Achieve at Random
The target for this indicator is within the upper and lower 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	75.5%	105	139	85%	Concern	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	76.5%	192	251	85%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	74.1%	100	135	85%	Concern	Achieve at Random

Feedback

What the chart tells us

Urgent referrals seen within 24 hours achieved 75.6% in May 2025.

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

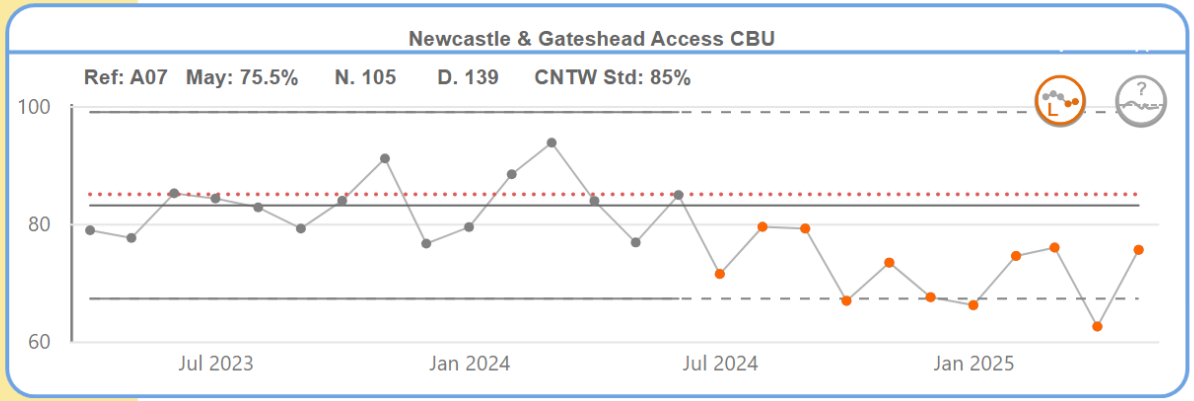
- Currently crisis staffing is challenging across all localities, active recruitment is underway, a rolling advert is place on the national NHS jobs portal within North Cumbria.
- Consideration for process when high levels of temporary staffing are used to support capacity to ensure methodology continues 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

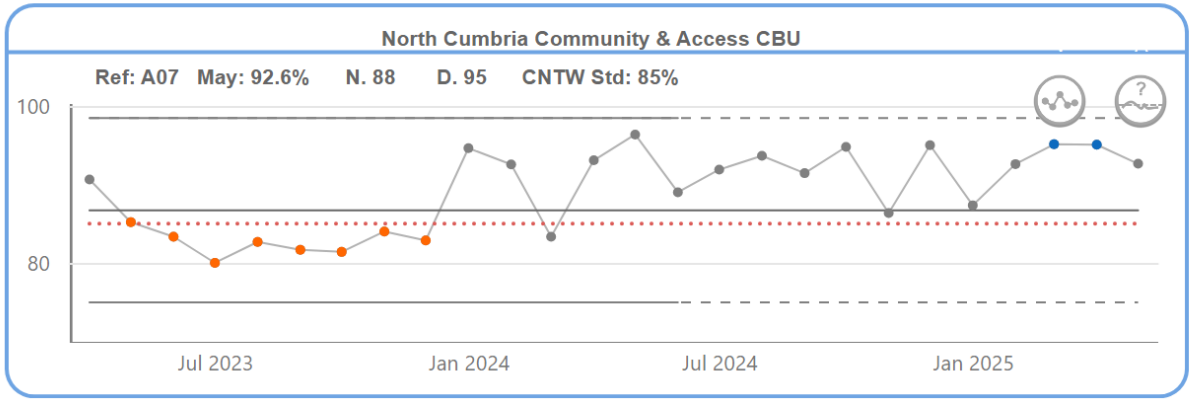
Expected impact and by when

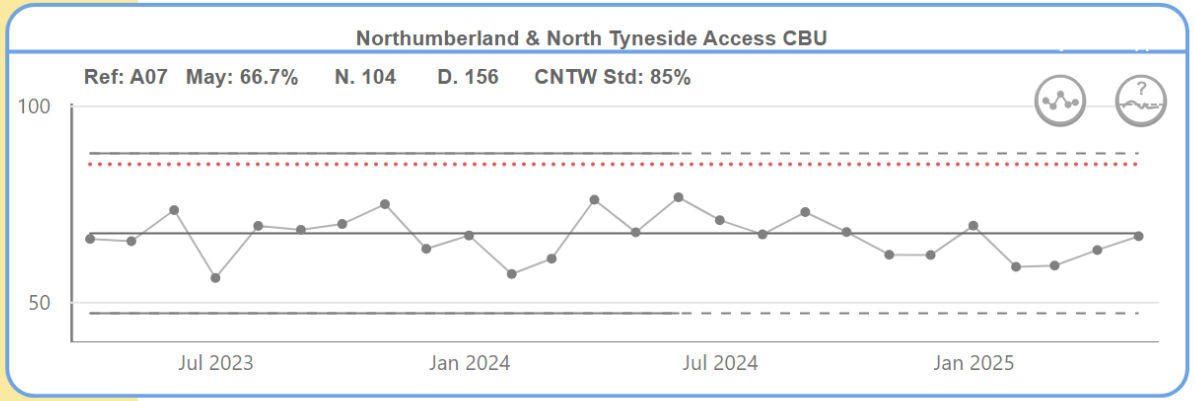
A recent decline has been observed, primarily due to short-term sickness, vacancies and clinical activity demand.

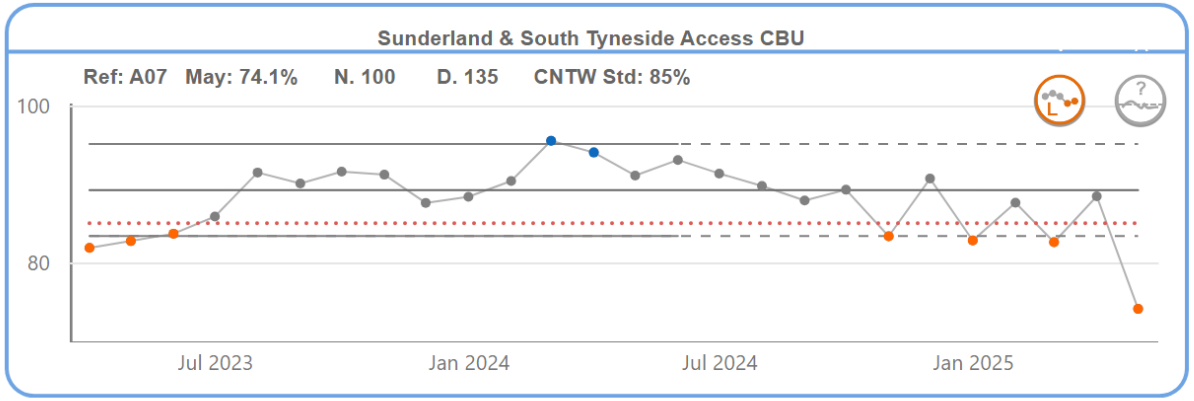
A07 Crisis % Urgent seen within 24 hours (WAA&OP)

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









Feedback

Performance:

- Newcastle and Gateshead, have deteriorated in the last 10 months and have been below the target with an average of 75% 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 since April 2024 and have an average performance of around 86%.
- Sunderland and South Tyneside are reported below target four times in the last seven months and have seen a significant deterioration in performance in May, but have remained above target prior to that for 16 months.

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

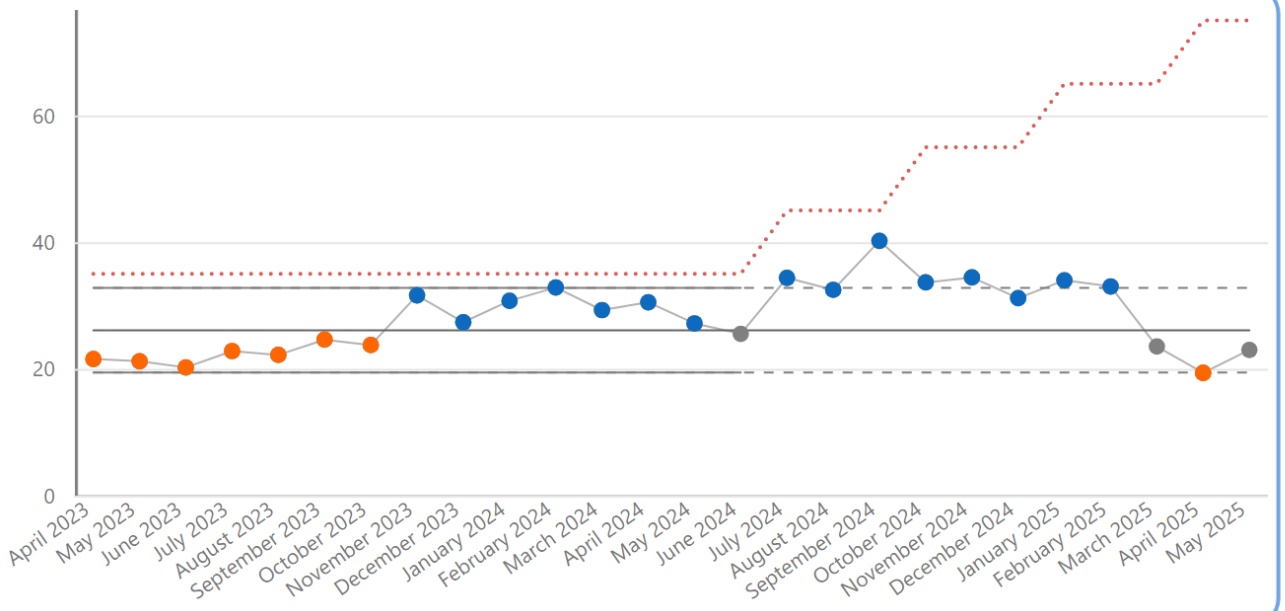
23.0%

tgt. 75%
n. 690
d. 3,000

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

Consistently Off Target
The target for this indicator is outside 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	29.7%	201	677	75%	Concern	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	20.5%	312	1,520	75%	Normal Variation	Consistently Off Target
Specialist Care Group (No Place Team)	39.8%	47	118	75%	Improvement	Consistently Off Target
Sunderland & South Tyneside Place Team	19.0%	130	685	75%	Concern	Consistently Off Target

Feedback

What the chart tells usThe p
Performance increased to 23.0% in May.

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.
- Staffing issues including sickness and vacancies in some teams impacting assessment capacity as cases are re-allocated.

Improvement Actions

- A significant amount of work has happened 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. Currently the trust benchmarks in the top 3 nationally (good) for the smallest proportion of waiters using the new methodology.
- Fortnightly waiting list meetings overseen by each team.
- Bi-monthly Access Oversight Group established with CBU's

Expected impact and by when
It is expected that performance continues to improve throughout 2025.

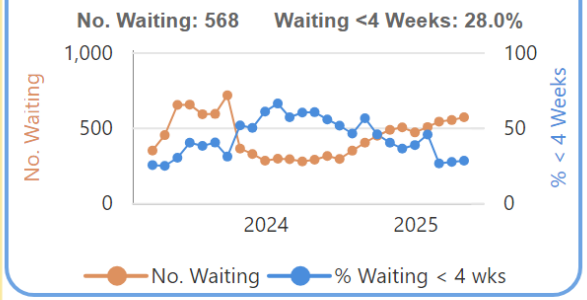
Working Age Adult and Older People Waits

Reporting Period: May-2025

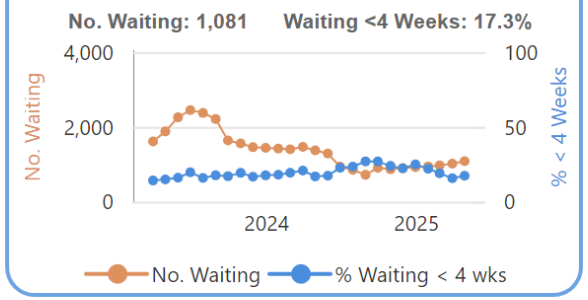
Pathway	Place Team Name	0-51 Weeks	52-77 Weeks	78-103 Weeks	Over 104 Weeks	Total
WAA	Newcastle & Gateshead Place Team	568	0	0	0	**568**
	North Cumbria & Northumberland & North Tyneside Place Team	927	101	32	21	**1,081**
	Specialist Care Group (No Place Team)	118	0	0	0	**118**
	Sunderland & South Tyneside Place Team	396	0	0	0	**396**
	Total	**2,009**	**101**	**32**	**21**	**2,163**
OPS	Newcastle & Gateshead Place Team	109	0	0	0	**109**
	North Cumbria & Northumberland & North Tyneside Place Team	439	0	0	0	**439**
	Sunderland & South Tyneside Place Team	289	0	0	0	**289**
	Total	**837**	**0**	**0**	**0**	837
Total		**2,846**	**101**	**32**	**21**	**3,000**

Working Age Adult Pathway by Place

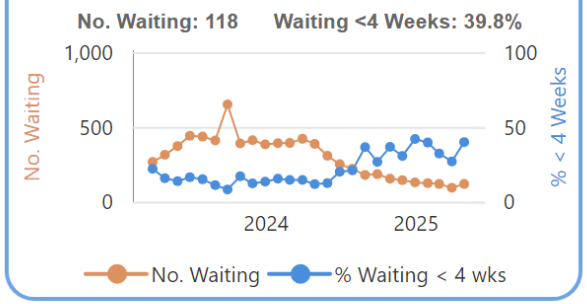
Newcastle & Gateshead Place Team



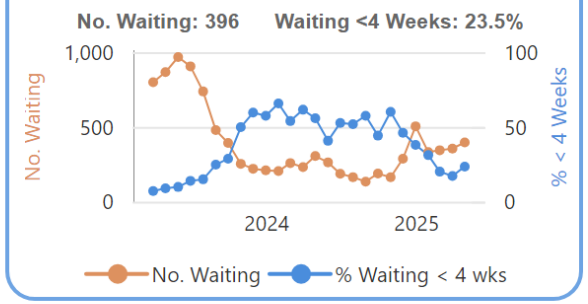
North Cumbria & Northumberland & North Tyneside Plac...



Specialist Care Group (No Place Team)

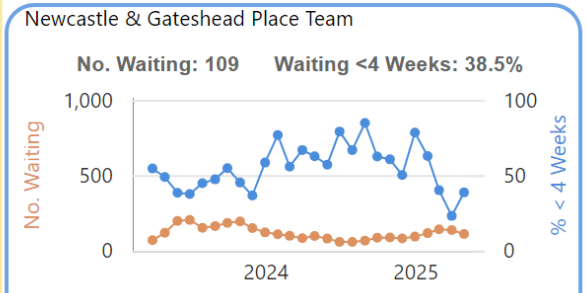


Sunderland & South Tyneside Place Team

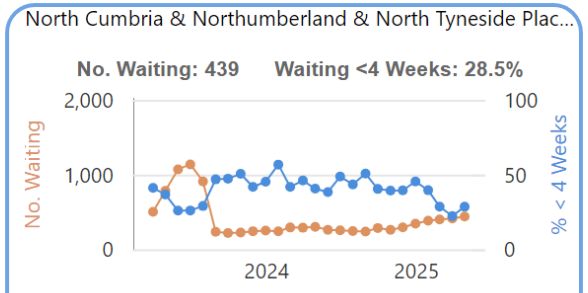


Older People Pathway by Place

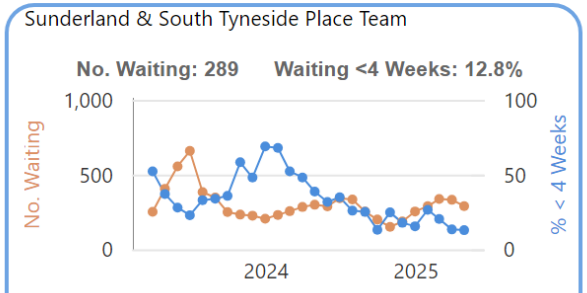
Newcastle & Gateshead Place Team



North Cumbria & Northumberland & North Tyneside Plac...



Sunderland & South Tyneside Place Team



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)

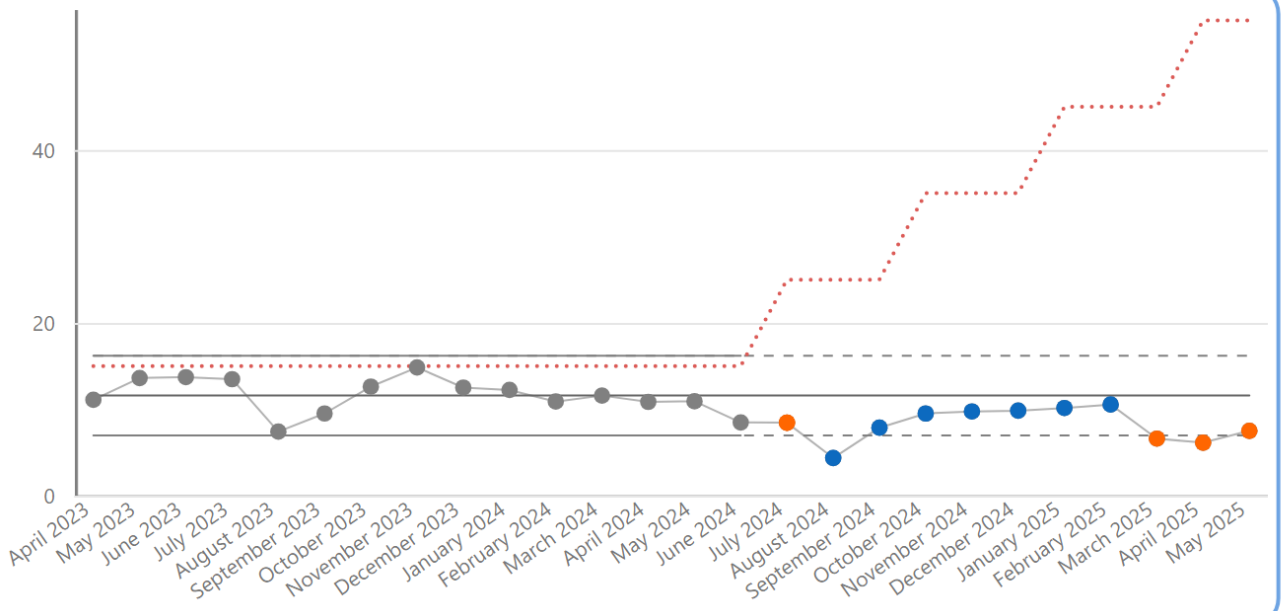
tgt. = target n. = numerator d. = denominator

7.5%		
	tgt.	55%
	n.	706
	d.	9,414

Concern
There is concern because this indicator is decreasing

Consistently Off Target
The target for this indicator is outside 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	5.7%	392	6,839	55%	Concern	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	9.8%	174	1,769	55%	Normal Variation	Consistently Off Target
Specialist Care Group (No Place Team)	7.2%	45	628	55%	SPC not applicable	SPC not applicable
Sunderland & South Tyneside Place Team	53.4%	95	178	55%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

7.5% of referrals have been waiting 4 weeks or less to receive help. 20% of CYPS on a Mental Health or Learning Disability pathway were seen within 4 weeks and only 4% of patients on a Neurodevelopmental Pathway were seen within 4 weeks.

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.
- Primary care stopping shared care agreements and NMPs/medics having to do all prescriptions is having an impact on seeing new patients.

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 and the team are implementing recording of other 'help' such as referral to Getting Help partners as a clock stop.

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.

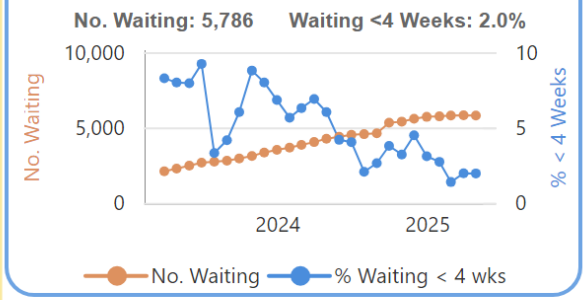
CYPS Waits by Pathway

Reporting Period: May-2025

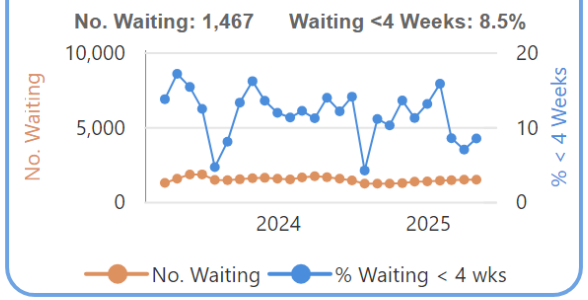
Pathway	Place Team Name	0-51 Weeks	52-77 Weeks	78-103 Weeks	Over 104 Weeks	Total
Neurodevelopmental	Newcastle & Gateshead Place Team	1,695	1,377	960	1,754	**5,786**
	North Cumbria & Northumberland & North Tyneside Place Team	804	207	158	298	**1,467**
	Specialist Care Group (No Place Team)	12	0	0	0	**12**
	Sunderland & South Tyneside Place Team	68	0	12	2	**82**
	CNTW	**2,579**	**1,584**	**1,130**	**2,054**	**7,347**
Mental Health & Learning Disability	Newcastle & Gateshead Place Team	956	10	19	68	**1,053**
	North Cumbria & Northumberland & North Tyneside Place Team	160	24	15	103	**302**
	Specialist Care Group (No Place Team)	193	18	2	403	**616**
	Sunderland & South Tyneside Place Team	76	8	8	4	**96**
	CNTW	**1,385**	**60**	**44**	**578**	**2,067**
All Pathways		**3,964**	**1,644**	**1,174**	**2,632**	**9,414**

Neurodevelopmental Pathway by Place

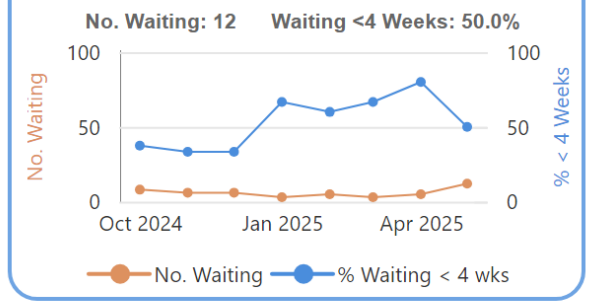
Newcastle & Gateshead Place Team



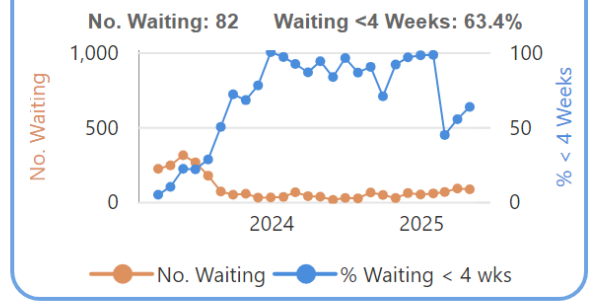
North Cumbria & Northumberland & North Tyneside Plac...



Specialist Care Group (No Place Team)

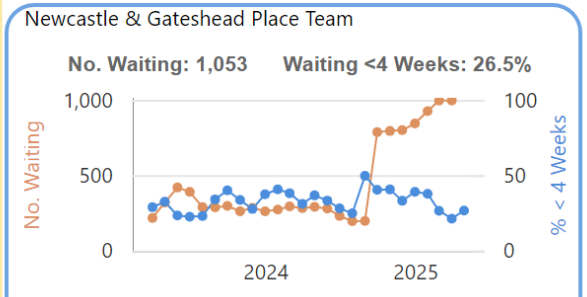


Sunderland & South Tyneside Place Team

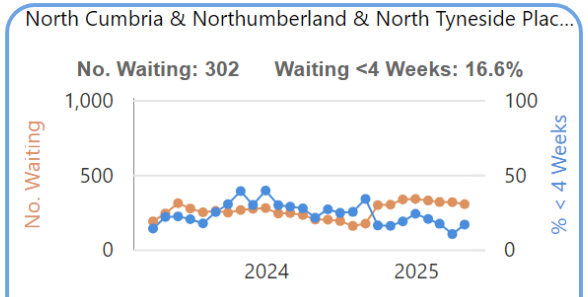


Mental Health & Learning Disability Pathway by Place

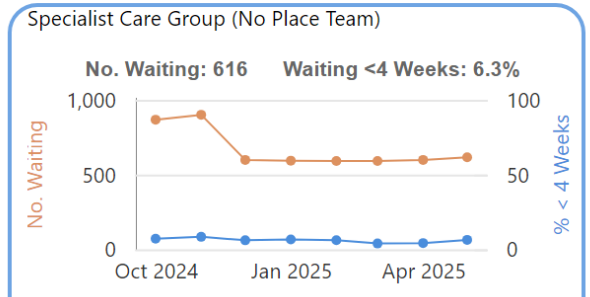
Newcastle & Gateshead Place Team



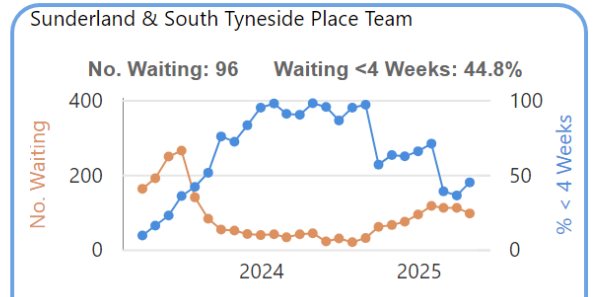
North Cumbria & Northumberland & North Tyneside Plac...



Specialist Care Group (No Place Team)



Sunderland & South Tyneside Place Team



A12 EIP – starting treatment in 14 days

Percentage of EIP referrals seen within 14 days (Q&P Metric 1400)

Risk Rating: Med (Monitoring)

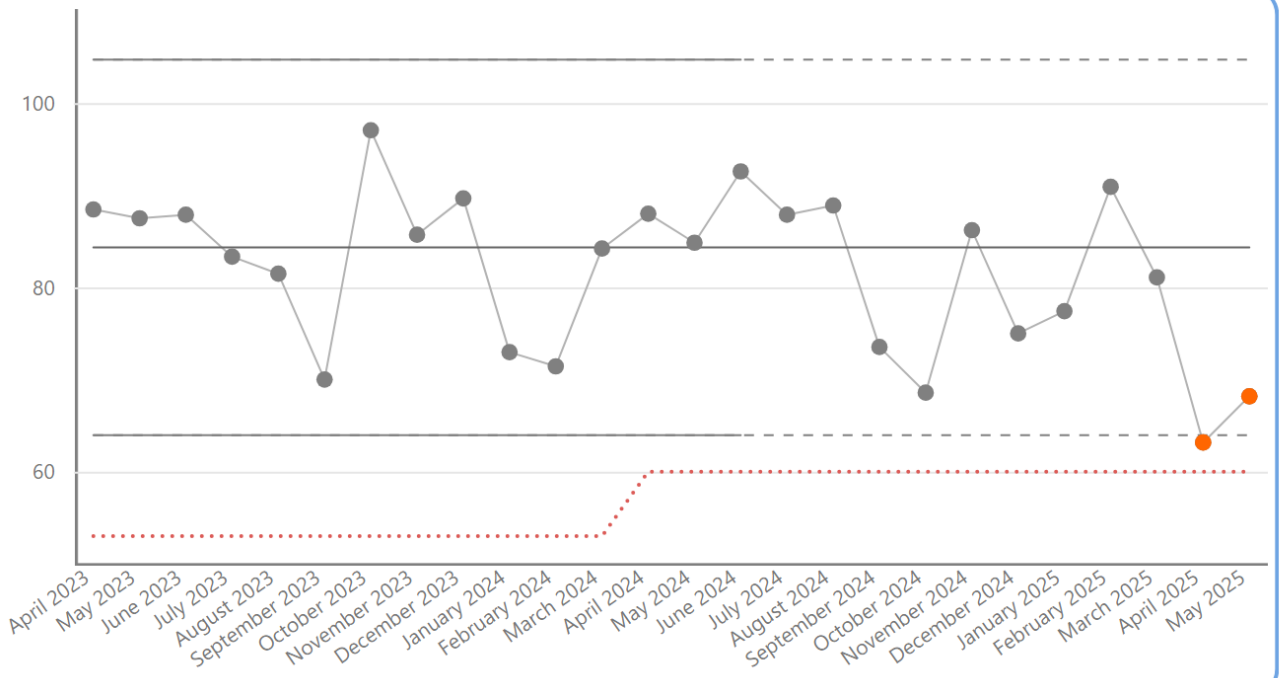
tgt. = target n. = numerator d. = denominator

68.2%	tgt.	60%
	n.	30
	d.	44

Concern
There is concern because this indicator is decreasing

Consistently Achieve
This indicator will consistently achieve the target

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	38.9%	7	18	60%	Concern	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	87.5%	14	16	60%	Normal Variation	Consistently Achieve
Sunderland & South Tyneside Place Team	90.0%	9	10	60%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Whilst the Trust remains above standard and has been for 24 months the metric performance has been below average for 2 of the last 3 months.

Root Cause of the performance issue

- The main additional element will be the implementation of specific actions to address high DNA rates and a review of assessment capacity. The plan is to offer an assessment in week one and, if DNA occurs, to re-offer in week two.
- Although all new referrals are currently being offered assessments within the 14-day target, DNA rates for EIP remain high at over 16% month on month.
- CTTs currently have very limited capacity to accept transfers from EIP due to a lack of available Band 6 staff. This shortage is being compounded by additional pressures on CTTs, including lithium monitoring responsibilities and a less episodic care approach for individuals with psychosis.
- A review of cases identified individuals who could potentially be discharged early from EIP and transferred to CTTs; however, due to ongoing capacity issues, these transfers cannot proceed as planned.

Improvement Actions

- CBU to review ARMS workforce requirements to explore releasing a Band 6 to support EIP – this will require wider Trust support.
- CCM and PM to conduct a detailed analysis of DNAs to identify any emerging themes or barriers.
- CCM and PM to reassess assessment capacity and implement a standard process to offer initial assessment in week one and re-offer in week two if DNA occurs.
- We are stepping down surge planning actions at this time, as CTTs do not have capacity to support additional transfers.

Expected impact and by when

Improved staffing in Quarter 2 may result in improved performance but acuity of patients and risk are the prevailing concerns.

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

Risk Rating: Low (No Target)

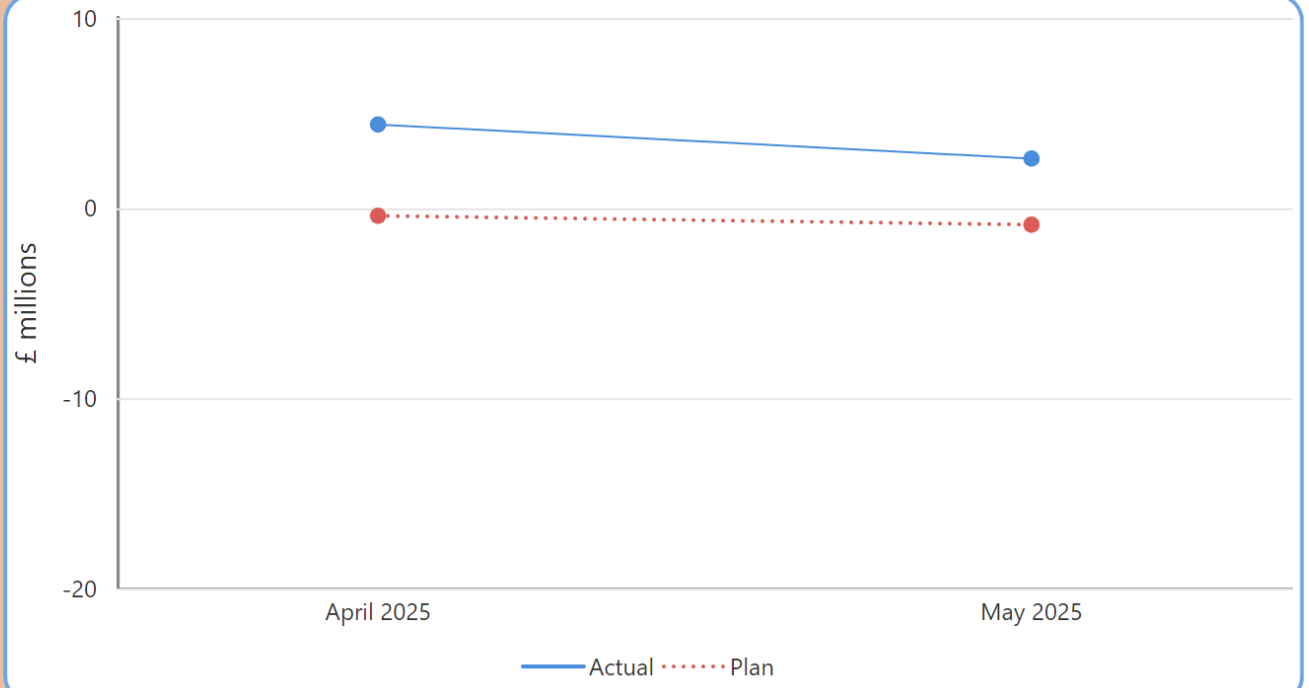
Live within our means (I&E Surplus/Deficit £)

£2.6m Plan -£0.9m

SPC not applicable
Insufficient data to determine either special cause or common cause variation

SPC not applicable
Assurance cannot be given as there is no target and/or process limits

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



Care Group	Actual	Plan	Variation	Assurance
Community Care Group	£6.4m	£7.1m	SPC not applicable	SPC not applicable
Inpatient Care Group	£1.4m	£1.8m	SPC not applicable	SPC not applicable
Specialist Care Group	£5.7m	£6.3m	SPC not applicable	SPC not applicable
Support & Corporate	-£10.9m	-£16.0m	SPC not applicable	SPC not applicable

Feedback

- 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.
- Weekly meeting to review and maximise the Trust cash balances.

S03 All staff WTEs

All staff WTEs

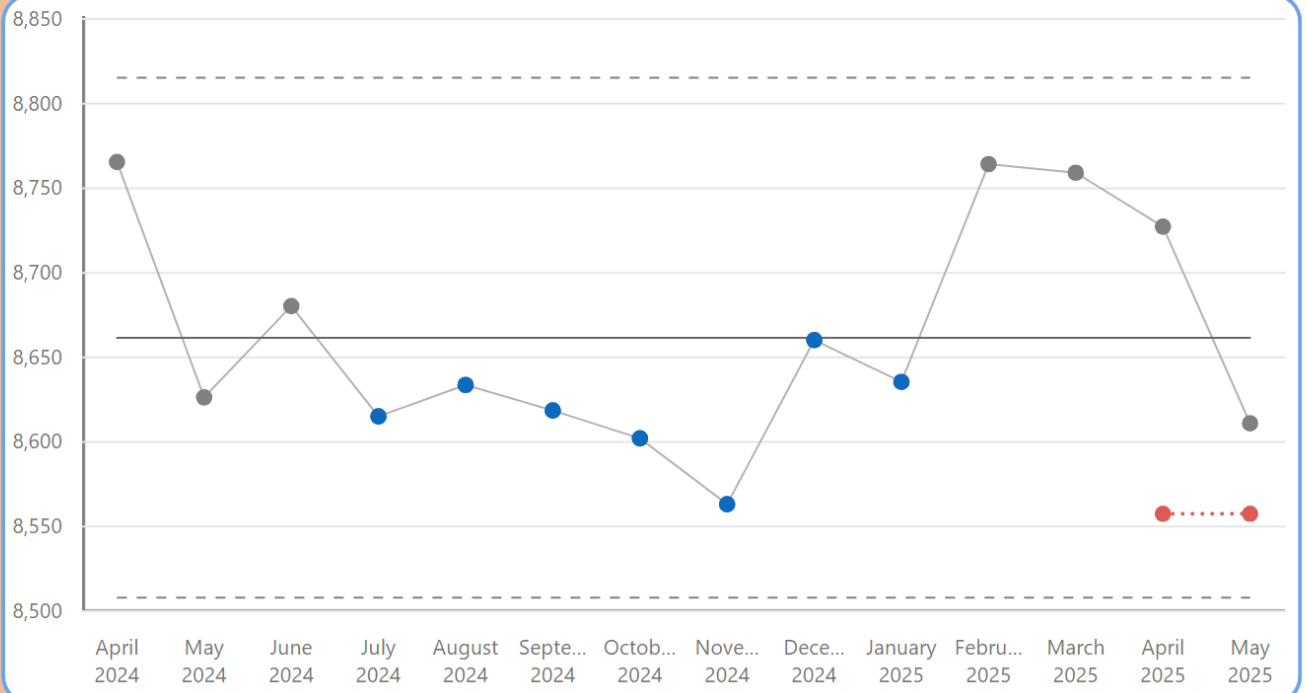
Risk Rating: Med (Monitoring)

8,611	Target 8,557

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

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

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



Care Group	Actual	Variation	Assurance
Community Care Group	3,035	Normal Variation	SPC not applicable
Inpatient Care Group	1,881	Improvement	SPC not applicable
Specialist Care Group	1,914	Normal Variation	SPC not applicable
Support & Corporate	1,781	Normal Variation	SPC not applicable

Feedback

- The trust was 54 WTE staff off the plan of 8,557 at Month 2

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 QandP Assurance report to Board - July 25.pdf

Report to the Board of Directors
23 July 2025

Quality and Performance Committee Quarterly Assurance Report
May 2025 – July 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 May 2025 – July 2025. Meetings were held on 7 May and 9 July.

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 and discussions on key areas of focus including community services waiting times, and an update on the work to redesign the neurodevelopmental pathway for Children and young People's and reduce restriction on MRE. At the May meeting of the Committee, the quality focus and deep dive centred on reducing restrictive practice across the wider Trust with significant assurance being received on the improvements made on this area.

4.2 Assurance relating to risk 2511

An update was provided on the Operational Pressure Escalation Level (OPEL) Framework which 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.

Regular Safer Staffing reports continue to be reviewed by the Committee noting the work to progress safer staffing tools implementation and benchmarking has commenced in partnership with colleagues in Tees Esk and Wear Valleys NHS Foundation Trust continues.

The Committee continues to receive CQC Compliance updates and review Must Do actions. The focus of the Committee at the May and July meetings related to receipt of the Learning Disability and Autism assessment report, and community services report respectively. The Committee received an update on the actions being taken in response to the assessments and the Committee reiterated the importance of providing assurance in terms of action taken and the impact of actions taken. The Committee will continue to monitor progress against the action plan.

The Committee were provided with an update on the actions taken to address the recommendations from the Limited assurance Internal Audit Report on Duty of Candour. The actions included increased oversight at the Trust wide Safety Group (TSG) and within groups-level. In response to an action relating to training, a short animation guide is underdeveloped to be included in inductions for staff.

In light of the recent CQC assessments for learning disability and autism services, community services and older people's services, the Director of Communications and Corporate Affairs asked that the Committee consider the framing and scoring of the current risk relating to compliance with CQC and quality standards. Following discussion, the Committee proposed an increase in the risk score from 15 (3 – possible x 5 – major) to 20 (4 – likely x 5 – major).

4.3 Assurance relating to risk 2512

Assurance in relation to a positive patient safety culture. 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). Five 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 the publication of independent reports and discussed the key findings from a recent case including the learning, the Trust's response and the link to the Trust's quality priorities.

The learning from the Shanley report, an independent review into Greater Manchester Mental Health NHS Foundation Trust was the Quality Focus and deep dive at the July meeting. A

presentation was delivered on the Trust's response to the recommendations from the report. The Committee will continue to monitor progress against the action plan.

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 and Support 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 and Support in the longer-term.

The Committee received an update on the changes to the operational governance framework sitting beneath the Executive Management Group. The framework enhances the focus on Trust wide learning and embedding of learning as well as monitoring the impact. The framework also reflects the new Model of Care and Support programme structures and monitoring of progress against individual projects.

An update on the Trust's Quality Aims and Priorities was provided and the alignment of these to the Trust's five strategic ambitions. The Committee will continue to receive updates on progress against achievement of the priorities throughout the year ahead.

4.5 Other issues and assurance received by the Committee

The Committee received the Annual Research and Development Annual Report and commended the service for its work during the year. The Trust's approach to Research and Development is fundamental to the achievement of the Trust strategic ambitions and Board members are encouraged to access the report on Team Engine.

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 review the neurodevelopmental pathway for children and young people, continue the reduction in the use of restrictive practice, approaches to managing, reporting and supporting incidents of self-harm, progress against the actions to address learning from the Shanley report, and progress against the CQC action plan for recent assessments.

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
July 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 - July 25.pdf

Report to the Board of Directors
23 July 2025

Mental Health Legislation Committee Quarterly Assurance Report
May 2025 – July 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 has been one meeting of the Committee during the period held on 9 July 2025.

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 legislation set out in the Mental Health Bill. The Committee continues to feel at present, risks associated with this are 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 July 2025

The Committee discussed panel members employment status following the Moon ruling. Legally privileged advice has been obtained and discussions have been held regarding the implications of the options available. A review of experiences in other organisations regionally and nationally will take place and an update will be provided to the October meeting.

In relation to improvements to care plans, the Deputy Director of Nursing and Therapies shared the outputs from the work to improve care planning across the Trust. The work has included workshops comprised of a range of multi-disciplinary teams' representatives as well as representation from service users and carers. The Committee took assurance from the update provided and the work undertaken to date but will continue to monitor this in terms of implementation and embedding of the new process/templates and in the light of comments from the CQC on Mental Health Act reviewer visits.

The Committee commended the work undertaken to increase panel member representation from ethnic minorities. Assurance was also provided in terms of the process in place for training and appraisal for panel members. An update on the panel review process was also provided which proposed annual self-appraisal, observation and appraisal at three years and at five years prior to any reappointment. The Committee will continue to monitor the implantation of this process.

The Committee noted improvements in performance in relation to the giving of rights for those on a Community Treatment Order. Although improvements were noted, the Committee will continue to monitor oversight to ensure improvements are sustained. The Board were asked to note the significant work being undertaken to improve the position in relation to completion of Parts A and Part B compliance and the potential impact of transfers into the Trust on compliance figures. Following an internal audit in relation to the compliance and quality, the form has been reviewed to simplify and separate Part A and Part B into an individual form. 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 continue to improve compliance.

The Committee also noted the continued increase in compliance with Mental Health Act training .

5. Ongoing areas of focus for the Committee

The Committee noted some challenges recently in terms of ensuring appropriate attendance at the Mental Health Legislation Steering Group and offered its support to address any issues. Attendance and meeting arrangements will be reviewed and any issues will be escalated to the Committee.

Regarding the CQC Mental Health Act reviewer visit reports, it was agreed that in future, reports would highlight themes so that issues relating to mental health legislation and issues of compliance can be sighted within the Committee for increased focus and visibility.

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 contents of the report and seek further assurance on any issues where appropriate.

Michael Robinson
Chair of Mental Health Legislation Committee
July 2025

2.3 CARE QUALITY COMMISSION - FINAL ASSESSMENT REPORTS

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

- Community Services
- Older People's Wards ? high level feedback

REFERENCES

Only PDFs are attached

2.3a CQC Assessments - Community and wards for older people.pdf

2.3b Board in public CQC Presentation 0.4.pdf

Meeting	**Board of Directors Public Meeting**		**Agenda item: 2.3**
Date of meeting	**Wednesday 23 July 2025**		
Report title	**CQC unannounced assessment of community based mental health services for adults of working age – Final Assessment Report and Actions** **CQC unannounced assessment of wards for older people with mental health problems**		
Report Lead	**Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance**		
Prepared by	**Vicky Wilkie, CQC Compliance and Governance Manager**		
Purpose	**For decision**	**For assurance**	**For awareness**
		X	
Report previously considered by	None.		
Executive summary	A brief summary of: - Community assessment February 2025, final report published 18 June 2025 - Assessment incorporates CQC's new Single Assessment Framework and Quality Statements - Overall rating for this service has dropped from outstanding to requires improvement - Trust has developed action plans to address areas of improvement / breaches of regulation - 3 day assessment of wards for older people with mental health problems 17 June 2025 - immediate high-level feedback received		
Detail of corporate/ strategic risks	SA1 Quality care, every day – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.		
Recommendation	To note content of community assessment report, ratings and actions To note the older people's wards assessment and immediate high-level feedback		
Supporting information / appendices	Presentation slides		

Board of Directors Public Meeting

Wednesday 23 July 2025

CQC unannounced assessment of community based mental health services for working age adults - Final Assessment Report

CQC unannounced assessment of wards for older people with mental health problems – high level feedback

1. Executive Summary

During February 2025, the Care Quality Commission (CQC) undertook a series of unannounced visits as part of an assessment of community based mental health services for adults of working age.

The Trust has received the final report from their assessment of community based mental health services for working age adults that took place in February.

The final report was received by the Trust on 11 June and was published on 18 June.

The assessment looked at all five key questions and has been assessed as requires improvement overall (a change from outstanding previously). Individual ratings for the five key questions are below:

Safe	Changed to Requires Improvement (previously Good)
Effective	Changed to Good (previously Outstanding)
Caring	Changed to Good (previously Outstanding)
Responsive	Remains Good
Well-led	Changed to Requires Improvement (previously Good)

CQC found two breaches of regulation in relation to staffing and governance:

- Regulation 17 Good Governance, in relation to the implementation of the lone worker policy, sharing learning from incidents, assessing and managing the safety of the environment, gaps in records and the consistency of management of waiting lists.

- Regulation 18 Staffing, in relation to supervision compliance levels and learning disability and autism training not being mandatory and having low compliance rates. Drug and alcohol awareness training was not accessed consistently across the teams we visited.

The action plans to address the breaches of regulation and areas of concern have been submitted to the CQC on 16 June.

On 17 June a three-day assessment of wards for older people with mental health problems commenced across all localities. A number of staff from a variety of disciplines, peer support workers, service users, carers and families were interviewed by the assessing teams. The Trust received high-level inspection feedback by way of a letter on 25 June 2025.

An action plan to address shortfalls from this assessment is currently being prepared but for the purposes of this report key themes from the high-level feedback include:

Positives:

- Assessors observed some good examples of protecting patients' privacy and dignity when providing personal care.
- Patient and carer feedback overall was positive across all wards, assessors observed some lovely interactions between staff and patients.
- Least restrictive practice and minimal blanket restrictions was demonstrated.
- Assessors reported a positive learning culture and involvement in quality improvement projects within Akenside and Castleside wards and good access to specialist services, i.e. podiatry and good links with the RVI (acute hospital) to admit straight to the wards.
- Care records were person centred, risks were identified, and appropriate mitigations were in place.
- Peer support worker roles seen as a positive asset.
- There was evidence of best interest decision making where required and family involvement, assessments were very person centred.
- MDT meetings were supportive inclusive and positive.
- The medicines inspector reported it was good to see self-administration supported, which included contact with community pharmacy for discharge.
- The use of antipsychotics in dementia was monitored well, no high dose antipsychotics seen.
- Families were offered copies of care plans where appropriate.
- Zonal observations were being used on Roker and Mowbray, feedback regarding the use of these was universally positive and staff told us it had significantly reduced unwitnessed falls and patient on patient assaults.

Areas for improvement:

- Concerns regarding same sex accommodation and privacy and dignity
- Medical staffing and behaviours on 2 wards
- Concerns of staffing vacancies expressed by some staff
- A lack of caring approaches and engagement with patients observed on one ward
- Environmental concerns on some wards in Cumbria
- Medicine inclusion and adherence to checking processes for emergency grab bags
- Use of intramuscular (IM) rapid tranquilisation and covert medication
- Basic Ligature risk assessments without ligature mapping in place

3. Recommendations

The Trust are required to develop and provide action plans in response to the concerns found during these assessments.

The Board are asked to:

- Note the contents of the report
- Note the action plan to address the 2 breaches of regulation and areas of concern from the community assessment
- Note the high-level feedback from the assessment of wards for older people with mental health problems

Name of author:	**Name of Executive Lead:**
Vicky Wilkie, CQC Compliance and Governance Manager	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance

16 July 2025

CQC ASSESSEMENT ACTIVITY

COMMUNITY SERVICES – FEBRUARY 2025
INPATIENT WARDS FOR OLDER PEOPLE – JUNE 2025

Assessment of community based mental health services for working age adults

- Assessment commenced 25 February 2025 for 3 days
- 12 community teams were visited
- All key questions were assessed using CQCs new Single Assessment Framework

Positives

- No concerns re infection prevention and control (IPC).
- Assured about safeguarding processes and governance, staff had appropriate training.
- Best interest decisions
- No concerns regarding medicines optimisation, evidence of good practice being followed and were assured by governance processes within Clozapine clinics.
- Timely & efficient MDTs – clear actions & risk management approaches.
- Positive home visits witnessed where treatment options were discussed.
- No complaints had been referred to the Ombudsman. Patients knew how to make a complaint.
- Staff knew how to deal with complaints appropriately seeking local resolutions where possible.

Positives

- Evidence of partnership working with 3rd sector, local authorities and housing.
- Staff demonstrated discrete, respectful behaviours. Patients were supported to manage their care and signposting to other support and help was evident.
- CQC observed people being treated as individuals.
- Patients reported feeling listened to. Staff were observed working in a person centred way. Patients felt involved in their care.
- Staff demonstrated increased support to patients when mental health deteriorated.
- Patients and carers had opportunities to give feedback.
- The Carers Promise was evidenced.
- Staff knew and were able to describe the trust vision. Staff described how they contributed to the discussions on the strategy for their service.
- Leaders had the skills, knowledge and experience to perform their roles.

Breaches of Regulation and areas of concern

Breaches of regulation

- **Regulation 17 Good Governance**

  - Gaps identified in operationalising the lone working policy.
  - Inconsistency in learning dissemination across care groups.
  - Environmental safety concerns.
  - Incomplete clinical documentation (care plans and risk assessments).
  - Inconsistent oversight of waiting lists.

Breaches of regulation

- **Regulation 18 Staffing**

  - Supervision compliance levels.
  - Learning disability and autism training not being mandatory and having low compliance rates.
  - Drug and alcohol awareness training was not accessed consistently across the teams visited.

Concerns to address

- **No standard referral and assessment process** for acceptance of referrals and access to CTT
- **Different assessment process** in the early intervention teams
- **Variability in waiting list management processes**, including approach to caseload management.
- **Improving Reading and recording of Rights**
- **Care Planning** – evidence and recording is poor, lack of personalisation vs planning care
- **Clinical risk assessment and Safety Planning**

Concerns to address

- **Lone Working** – policy and application
- **Safe Environments** Variability of environmental safety assessments across community premises, including security
- **Safe Environments** – ligature risk assessments (gaps)
- **Fridge temperature** compliance was poor

Concerns to address

- **Learning Culture** – incidents/complaints/Freedom to Speak Up not shared across CBUs and teams/Lack of standard team meeting agendas to discuss learning from incidents and complaints
- **Staffing/Vacancies**
- **Clinical supervision compliance** was poor
- **Learning disability and autism** training compliance
- **Drug and alcohol training** compliance was poor

Actions we are taking

Different assessment process in the early intervention teams	• Standard assessment process to be confirmed and implemented across all EIP teams based on national standards by 30/09/25.
No standard referral and assessment process for acceptance of referrals and access to CTT.	• Standard referral and assessment process to be agreed and implemented by 30/09/25.
Variability in waiting list management processes, including approach to caseload management.	• New policy to be developed and implemented for waiting list management across the Trust by 31/10/25. • Clarification to be agreed on use of information and data to support waiting list management approaches in teams 31/10/25.
Improving Reading and recording of Rights	• Staff reminded of their obligations under the policy framework to ensure compliance. Trust MHL Specialist to deliver training across all Community CBUs 31/07/25.

Actions we are taking

Learning Culture – incidents/complaints/F2SU not shared across CBUs and teams Lack of standard team meeting agendas to discuss learning from incidents and complaints	• Revised operational governance and delivery meetings from BDG/Group/CBU approved by EMG on 30/06/2025 and to be fully implemented by 31/08/2025. • New Care Group Learning meetings to be established with clear agendas to strengthen cascade and learning from incidents and complaints by 31/08/2025.
	• CBU to team level meeting agendas to be standardised across all community and access teams by 31/07/2025.
	• Learning improvement webinar to be updated to focus on learning from Patient Safety Incident Investigations (PSIIs) across the Trust by 30/09/2025.
	• Safety webinars to be expanded across pathways and condition specific learning through revised clinical network structure by 31/10/2025.
	• 'Hierarchy of learning' to be developed to support all staff and teams on how we share and embed learning by 28/02/2026.
	• Tools and techniques to support learning to be reviewed by safer care team (i.e. 7 minute brief, thematic analysis, staff animation) by 31/10/2025.

Actions we are taking

Lone Working – policy and application	• Clarify and update requirements for staff risk assessment in the PGN by 31/07/2025.
	• Internal audit to complete review of current working practices to ensure compliance with the PGN 31/07/2025.

Care Planning – evidence and recording is poor, lack of personalisation vs planning care	• All teams to ensure compliance with care planning metrics are reviewed weekly by clinical teams to address areas of under performance and non-compliance 31/08/25.
	• Outcomes from monthly care planning audits to be improved in relation to management action and improvement to be demonstrated across CTT by 31/08/25.
	• Trust quality priority for improving care planning identified for 25/26 with milestones for delivery agreed by 31/07/25.
Clinical risk assessment and Safety Planning	• Performance monitoring for compliance with safety planning to be enhanced across all CTT to support teams in achieving the required standards by 31/08/25.
	• Quality Aim agreed in line with Quality Priorities for 2025/26 to develop a consistent and evidence-based approach to risk assessment and safety planning across all services with milestones agreed. By 31/07/25.

Actions we are taking

Safe Environments Variability of environmental safety assessments across community premises, including security.	• Standard for environmental assessments to be clarified in policy and practice. This must include clarification on security by 30/09/25.
	• Standard (as per above) to be implemented and audited against in Q4 for compliance.
	• Clarification on use and access of staff attack alarms for community premises to be completed by 30/09/25.
Safe Environments ligature risk assessments	• Gaps identified in ligature risk assessments completed to be addressed and updated by 30/09/25.
Safe Environments Variability of environment/access to equipment/needs of patients with mobility issues	• Assessment of suitable environment/equipment to be completed for all community bases (To be agreed with NTW solutions)
Fridge temperature compliance was poor	• Team monitoring arrangements to be reinforced with clear leadership roles to ensure compliance 31/08/25.
	• Electronic solution (MyKit) to be implemented to address human error by 30/11/25.

Actions we are taking

Staffing/Vacancies	• Hotspot areas where staffing is consistently and significantly a challenge to be reviewed and risk assessed to ensure actions are clear in the short to medium term 31/08/25. • Budget and actual staffing position continues to be reviewed monthly as part of the financial delivery plan 31/05/25.
Clinical supervision compliance was poor	• Teams consistently under performing against clinical supervision standards to be identified with clear actions to improve compliance 31/08/25.
	• Internal Audit to review on-line recording system and monitoring process in relation to clinical supervision 30/09/25.
Learning disability and autism training compliance	• Learning disability and Autism training now mandatory for all clinical staff in accordance with Health and Social Care Act 2022 by 31/05/2025.
	• Trajectory for improvement to be prioritised for clinical teams and agreed 30/09/25.
	• Method of delivery for all staff to be reviewed to ensure compliance with the Act and deliverability for all trust staff by 30/09/25.
Drug and alcohol training compliance was poor	• Training Needs Analysis for community staff to be explored, agreed and rolled out across teams by 30/06/25.

Assessment of wards for older people with mental health problems

- On 17 June 2025 a three-day assessment of wards for older people with mental health problems commenced across all localities.
- A number of staff from a variety of disciplines, peer support workers, service users, carers and families were interviewed by the assessing teams.
- The Trust received high-level inspection feedback by way of a letter on 25 June 2025.
- The draft report to be received

Positives

- Patient and carer feedback overall was positive across all wards, assessors observed some lovely interactions between staff and patients.
- Good examples of protecting patients' privacy and dignity when providing personal care.
- Least restrictive practice and minimal blanket restrictions was demonstrated.
- A positive learning culture and involvement in quality improvement projects within Akenside and Castleside wards and good access to specialist services, i.e. podiatry and good links with the RVI (acute hospital) to admit straight to the wards.
- Care records were person centred, risks were identified, and appropriate mitigations were in place.
- Peer support worker roles seen as a positive asset.
- There was evidence of best interest decision making where required and family involvement, assessments were very person centred.
- MDT meetings were supportive inclusive and positive.
- The medicines inspector reported it was good to see self-administration supported, which included contact with community pharmacy for discharge.
- The use of antipsychotics in dementia was monitored well, no high dose antipsychotics seen.
- Families were offered copies of care plans where appropriate.
- Zonal observations were being used on Roker and Mowbray, feedback regarding the use of these was universally positive and staff told us it had significantly reduced unwitnessed falls and patient on patient assaults.

Areas for improvement

- Concerns regarding same sex accommodation and privacy and dignity
- Medical staffing and behaviours on 2 wards
- Concerns of staffing vacancies expressed by some staff
- A lack of caring approaches and engagement with patients observed on one ward
- Environmental concerns on some wards in Cumbria
- Medicine inclusion and adherence to checking processes for emergency grab bags
- Use of intramuscular (IM) rapid tranquilisation and covert medication
- Basic ligature risk assessments without ligature mapping in place

Applying the learning from our 3 core service inspections over the last 12 months

- Cross care group reflection on learning held 4 July 2025.
- Identifying outliers on performance and ‘everyday’ standards.
- Work already commenced on policy and practice review.
- CQC Compliance Group – proactive view on compliance (not just retrospective).

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

Darren Best, Chair

3.1 YEWDALE WARD - PROGRESS UPDATE REPORT

REFERENCES

Only PDFs are attached

3.1 Yewdale Ward Board Update July_.pdf

Meeting	**Board of Directors**		**Agenda item: 3.1**
Date of meeting	Wednesday 23 July 2025		
Report title	Yewdale Ward – ICB Independent Review Update		
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	Strategic Case for Change considered and approved by the Board in April 2025		
Executive summary	Following the Board of Directors decision in April 2025 to approve the changes in adult acute inpatient provision in Whitehaven, the Trust were informed the ICB would be undertaking a review of the process followed by the Trust and the ICB as the commissioner of the service. Extensive work by the Trust and ICB colleagues has taken place during May and June to support this review. In July the ICB presented their findings to the ICB Service Change Advisory Committee (SCAC) and the ICB have written to the Trust outlining the following: The Group (SCAC) was supportive of the approach outlined in the paper, and endorsed the proposal that CNTW should use the forthcoming Health Overview and Scrutiny Committee (HOSC) meeting on 17 July to provide an update on the current position. This included: • Sharing the position of the independent review commissioned by the ICB • Outlining to HOSC the range of options considered and explaining why certain options were discounted as not viable in determining the current proposed service change • Providing assurance on the implementation of other aspects of the clinical model, including investment in community and crisis services such as Hope Haven. The Group also requested confirmation of the following: • Impact on patients being cared for Out of Area. • Continued work with North West Ambulance Service on any additional travel implications/increased demand for ambulance support. • The Trust to revisit and strengthen the travel impact assessment carried out as part of the strategic case for change.		

	• Progress being made on implementing the Hope Haven clinical model. The Trust is in the process of responding to the ICB following the outcome of the SCAC meeting. On 17th July the Trust attended the Health Overview and Scrutiny Committee (HOSC) to progress with the above points and provided the committee with an update on the current position of the independent review and progress with Hope Haven. An update on the discussions held at the committee will be fed back to Board members. A Quality Impact Assessment (QIA) remains in place for the patients currently being cared for on Yewdale Ward and the mitigations in place given the low occupancy of the ward, pausing to new admissions and safe staffing levels. The Trust will continue to update the ICB on this position as part of daily review of quality and service delivery.
Detail of corporate/ strategic risks	Isolation of Yewdale Ward remains as a Corporate Risk.
Recommendation	The Board are asked to note: • The outcome of the ICB Service Change Advisory Committee meeting. • The discussion with HOSC on 17 July 2025. • The ongoing QIA in place for Yewdale Ward.
Supporting information / appendices	None.

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 - July 25.pdf

Report to the Board of Directors
23 July 2025

People Committee Quarterly Assurance Report
May 2025 – July 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

There has been one substantive meeting of the Committee during the period. This was held on 11 June 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 May – July 2025

4.1 Assurance relating to risk 2542

The Workforce Metrics performance report continues to inform the People Committee Agenda on areas such as absence, training, induction, appraisal and recruitment as well as some of the metrics relating to culture such as exit data and staff surveys.

With regards to training, continued improvement was noted on individual training topics. Learning Disability and Autism training has been included as essential training for all clinical staff following CQC feedback.

The Committee noted that sickness absence remains above target and work continues as previously reported. Mental health continues to feature as the highest reason for absence and initiatives in place to support people back to work including specific initiatives from care groups continue. There is a key focus regionally on how the Health and Growth Accelerator can support absence reduction and also work ongoing with the Regional Wellbeing Hub.

Following marginal improvement in appraisal compliance, the Committee discussed the importance of being clear about the value of appraisals. An evaluation is now sent to people following appraisal and information is collated and evaluated by the Workforce Development

Team. The Appraisal Policy has recently been reviewed and more detail on the importance of ensuring appraisals are meaningful has been included. The Trust will be moving to ESR recording for appraisals later in the year which will provide more accurate data. At the same time appraisal completion (along with other key workforce metrics) will be a requirement to progress salary increment.

The committee received the Guardian of Safe Working report and noted that completeness of exception reporting fell below 100%. This is being supported by the Guardian of Safe Working.

The Committee discussed staff turnover and noted areas that consistently operate at much higher turnover rates and vacancies. It was recognised that this has been a longstanding challenge in the Cumbria footprint. Escalation meetings are taking place operationally to address the medical staffing risks and more broadly around workforce supply and demand. The risks associated with this are captured on the Trust's Corporate Risk Register and is reviewed on an ongoing basis by the Executive Management Group.

An update on immigration policy changes and the impact was provided. The Trust is following national legislation and staff, collectively and individually are being supported during this difficult time.

4.2 Assurance relating to risk 2544

The Committee received an update on health and wellbeing initiatives across the Trust which provided a good level of assurance of work to support the wellbeing of staff and the reduction of sickness absence across the Trust in a proactive and holistic way. The Committee discussed future provision for mental health support in relation to the regional offer being developed.

Due to the decommissioning of the Staff Psychological Centre, no annual report was available. In terms of the Health and Growth Accelerator, additional money is available for this year to have a further enhanced model and that is currently being worked through. It is likely to be extended beyond mental health support to physical health such as menopause, obesity, drug and alcohol, tobacco etc. The key piece of work is to look at the offer beyond April 2026. It has been agreed that the Mental Health and Wellbeing Hub will become one of the five key delivery groups under the Scaling Up Programme. Working together as a region will ensure a Mental Health and Wellbeing Hub to support the region in a consistent way.

The Committee received the Equality, Diversity and Inclusion (EDI) action plan update and the EDI Annual Report for 2024/25. The Committee received a good level of assurance on progress against the actions. It is important to note that actions were finalised prior to the Supreme Court Ruling around how sex should be interpreted under the Equality Act. The Equality and Human Rights Commission is currently undergoing a national consultation that may result in changes to the Code of Practice, and it is important to note for assurance that it is likely further actions would need to be agreed following this.

Two of the Trust's Freedom to Speak up Guardians attended the meeting to provide an update on raising concerns. There has been an increase in cases reported since the previous reporting period and appears to be the same trend as previous years. Management process remains one of main reasons for reporting in terms of people going through employee relations processes, with behaviours being another key theme. During the reporting period, the number of Freedom to Speak Up Guardians (FTSUG) increased from two to four which has increased capacity. The Raising Concerns Policy has been reviewed and the Trust has continued to adopt the national policy with some local amendments where appropriate. The Resolution Policy had been implemented, moving away from the Grievance Policy and the Trust wide Leadership Programme continues to be rolled out with leadership and culture key modules for discussion.

4.3 Other issues and assurance received by the Committee

The Committee discussed the previous year's Trust annual priorities which come under the Great Place to Work ambition:

- Refresh the development offer for teams/individuals
- Refresh the Trust's freedom to speak up approach
- Measures to address key Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators
- Improve employee relations processes
- Support the wellbeing of staff
- Recognise the importance of veterans in service delivery and employment

An overview of the key points under each of these priorities was provided. Active discussions are taking place operationally with the aim of focusing on the Trust's five strategic ambitions throughout the course of the year in the context of the annual plan.

5. Ongoing areas of focus for the Committee

Over the next 12 months+, the Committee will continue to focus on:

- Key hotspot areas in Cumbria in relation to recruitment and retention.
- A deep dive into medical recruitment vacancies in terms of accuracy of data or themes.
- Assurance on the Trust's Model of Care and Support and transformation schemes and the impact in terms of workforce, and the link to longer-term workforce planning.

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
July 2025

4.2 EQUALITY, DIVERSITY INCLUSION ANNUAL REPORT 2024/25

Lynne Shaw, Executive Director of Workforce and Organisational Development

REFERENCES

Only PDFs are attached

4.2 EDI Annual Report 2025.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Meeting	Trust Board of Directors		**Agenda item:**
Date of meeting	Wednesday 23 July 2025		
Report title	Equality, Diversity & Human Rights Annual Report 2024-25		
Report Lead	Lynne Shaw, Executive Director of Workforce and Organisational Development		
Prepared by	Chris Rowlands, Equality, Diversity & Inclusion Lead Emma Silver Price, Equality, Diversity & Inclusion Officer		
Purpose	**For decision**	**For assurance**	**For awareness**
			X
Report previously considered by	People Committee (June 2025)		
Executive summary	This document is produced in line with our statutory requirements under the Equality Act 2010 to report on work that has taken place over the previous year and to outline Equality Objectives for the coming year(s). Once received and approved its publication will meet the Specific Duties of the Equality Act 2010 to publish: • Equality Objectives, at least every four years • Information to demonstrate their compliance with the Public Sector Equality Duty The report details metrics in line with the following statutory/regulatory requirements, as well as agreed actions to address the disparities shown: • Workforce Race Equality Standard • Workforce Disability Equality Standard • Gender Pay Gap Finally, the report gives a snapshot of some of the work undertaken over the past year		

	including the relaunch of the Give Respect Get Respect campaign, bullying survey and launch of the reasonable adjustments toolkit, alongside some key work from our four staff networks. Alongside the regulatory requirements noted above, the work contained within the report also supports the learning from Nottinghamshire work underway across the Trust.
Detail of corporate/ strategic risks	SA3 – 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	Board of Directors is asked to note the content of the report for awareness prior to publication. The People Committee has approved the content at its meeting in June 2025.
Supporting information / appendices	N/A

Trust Board of Directors
Wednesday 23 July 2025

Equality, Diversity & Human Rights Annual Report 2024-25

Introduction

This report highlights the work undertaken by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust during the past year to make the NHS a better and fairer place for patients and staff. The report covers the period from April 2024 to the end of March 2025. The work helps us to meet our Equality Objectives which were agreed at the end of 2023.

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

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

Key highlights for the Equality Diversity and Inclusion Team this year have been working closely groups and staff networks, particularly around cultural awareness. The coming year for EDI in the Trust will see an important focus on health inequalities and we will be working with the communities which we serve to best meet those needs.

We hope you enjoy reading about our work in the past year, and we look forward to telling you about our busy year ahead.

Equality, Diversity & Inclusion Objectives 2024-25

During 2024-25 we began work to address the Equality Diversity and Inclusion Objectives that were agreed at Trust Board at the end of 2023. The objectives are to:

- Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

- Address progression within the Trust for staff protected under the Equality Act 2010.
- Engage with racialised and ethnic minority communities to identify and agree core organisational competencies requiring further development.

At the beginning of September, the Integrated Care Board asked for an update on our progress against NHS England's Equality Diversity and Inclusion Improvement Plan. Actions are on track. Key areas we need to continue to work towards are:

- Create and implement a talent management plan to improve the diversity of executive and senior leadership teams and evidence progress of implementation. The roll out of our new Leadership Programme will contribute to this.
- Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory.
- Have mechanisms to ensure staff who raise concerns are protected by their organisation. We know from the bullying survey that we conducted this year that we still need to work towards ensuring that all our staff feel safe and supported to raise a concern. There will be an opportunity to refresh our approach to this with new Freedom to Speak up Guardians and consider how Freedom to Speak up Champions could play a bigger role.

Patient and Carer Race Equality Framework (PCREF)

Work has commenced on developing our Patient Carer Race Equality Framework. A meeting took place at the end of September with Community Leaders that established next steps for the work. We have collated data in line with the Framework's technical guidance that will continue to inform our discussions with communities to co-produce a set of actions early in 2025-26.

Workforce Race Equality Standard (WRES)

The most recent WRES Report (24/25) was published in August 2024. The data compiled within this report is from a snapshot taken on 31 March 2024, as well as findings from the most recent NHS Staff Survey which took place in Autumn 2023.

Metric	CNTW Figures for Latest Reporting Period			CNTW Figures for Previous Reporting Period			2024 Trend (2023 in brackets)
	White	BME	Comments	White	BME	Comments	
Non-clinical Staff	1495	47	BME 11% of total workforce	1548	52	BME 9.06% of total workforce	BME workforce has grown
Clinical Staff	5536	685		5387	509		
Medical Staff	166	165		152	153		
Non-Clinical Band 5 or below	1160	39	3% of non-Clinical staff are BME	1243	43	3.2% of non-Clinical staff are BME	82.9% BME (82.5%) vs 77.6% (77%) white staff in Band 5 or below. Marginal change.
Clinical Band 5 or below	2572	543	10.9% of Clinical	2566	374	8.6% of Clinical staff	79.3% BME (73.5%) vs

			staff are BME			are BME	46.5% white staff (47.6%) in Band 5 or below. Significant growth during reporting period. Planning and monitoring for progression will be key.
Medical Consultant Grade	121	91	49.2% of Medical staff are BME	116	88	50.2% of Medical staff are BME	55.1% BME (43.1%) vs 72.8% white (56.8%) Consultant Grade staff
Staff appointed from shortlisting	759 (3517 shortlisted)	276 (1918 shortlisted)	White applicants 1.48 times more likely to be appointed	1405 (4128 shortlisted)	215 (1339 short-listed)	White applicants 2.12 times more likely to be appointed	Improvement over the last 4 reporting periods
Staff entering formal disciplinary process	54	12	BME staff 1.76 times more likely to be in formal process	76	12	BME staff 1.57 times more likely to be in formal process	Slight deterioration
Staff accessing non-mandatory training & CPD	Not recorded by Group Workforce Teams and therefore unable to be reported on.			Due to staff not accessing non-mandatory training during the pandemic, it was not possible to calculate the figure. The 2020 return showed that BME staff were 1.5 times more likely than White staff to access non-mandatory training.			N/A
% Staff experiencing bullying, harassment or abuse from patients, relatives or public	24.7%	36.55%	11.85% point disparity gap	26.6%	36.2%	9.6% point disparity gap	Experience of white staff has improved between 2022 to 2023, with marginal deterioration for BME staff. The disparity gap has increased.
% Staff experiencing bullying, harassment or abuse from staff	15.02%	21.28%	6.26% point disparity gap	13.6%	24.1%	10.5% point disparity gap	The experience of white staff has deteriorated and returned to 2020-21 levels. The experience of BME staff has improved by 2.82% points and the disparity gap has decreased.

% Staff believing organisation provides equal opportunities for career progression	64.27%	53.45%	10.82% point disparity gap	68.2%	50.2%	18% point disparity gap	There has been an improvement for BME staff but a decrease for white staff. Despite this, there is still a disparity between white and BME staff, although there has been a significant improvement this year.
% Staff experiencing discrimination from manager, team lead or colleague	5.53%	15.57%	10.04% point disparity gap	4.8%	17.3%	12.5% point disparity gap	There has been an improvement for BME staff but a deterioration for white staff. Despite this, there remains a large disparity between white and BME staff however the disparity gap has improved over the last reporting period.
% Trusts Board membership compared to overall workforce	85.71%	14.29% (overall workforce is 11% BME)	BME Board Members averaged 10.6% across North East and Yorkshire (2023 National WRES)	92.3%	7.7% (overall workforce was 9.06% BME)	BME Board Members averaged 9.3% across North East and Yorkshire (2022 National WRES)	The Trust Board is more representative than the overall BME workforce.

Key Findings

- BME staff make up 3% of the overall non-clinical workforce, yet 82.9% of BME staff are in band 5 or below. This is compared to 77.6% of white staff in band 5 or below.
- BME staff make up 10.9% of the overall clinical workforce, yet 79.3% of BME staff are in band 5 or below. This is compared to 46.5% of white staff in band 5 or below.
- Despite BME staff making up nearly half (49.2%) of the overall medical workforce, only 55.1% are at Consultant grade. This compares to 72.8% of white medical staff being at Consultant grade. White medical staff at Consultant grade

increased by 16% points, and BME medical staff at Consultant grade increased by 12% points. There is a 17.7% point disparity between BME and white medical staff at Consultant grade (13.7% point disparity last year).

- The percentage of staff experiencing bullying, harassment or abuse from patients, relatives, or the public has marginally increased for BME staff, and marginally decreased for white staff. Despite marginal differences, the disparity gap between the experience of BME and white staff has widened to 11.85% points, the disparity last year was 9.6% points.
- The percentage of BME staff believing the organisation provides equal opportunities for career progression has increased by 3.25% points, however the result for white staff has deteriorated by 3.93% points. There is a 10.82% point disparity between BME and white staff according to the NHS Staff Survey 2023 (this gap was 18% in 2022).

Actions

- Continue work to address progression opportunities for staff as part of agreed Trust Equality Objectives.
- Relaunch Give Respect Get Respect in conjunction with a research study into the experience of bullying in collaboration with the National Institute for Health and Care Research and with the Trust Research Innovation and Clinical Effectiveness team. The study will be informed by evidence-based research and will propose interventions that will be designed to reduce incidences and disparity between experiences in relevant WRES Metrics.
- Introduce a campaign for 'My Equality and Diversity' reporting within the Electronic Staff Record (ESR). The aim of the campaign will be to encourage staff to update their ethnicity within ESR, which will also contribute towards data collection for race pay gap reporting.
- Establish an EDI dashboard and run quarterly checks on data to pinpoint any areas of concern.
- Relaunch the Cultural Ambassador programme and consider Cultural Ambassador involvement within recruitment processes.

Workforce Disability Equality Standard (WDES)

The most recent WDES Annual Report (24/25) was published in August 2024. The data compiled within this report is from a snapshot taken on 31 March 2024, as well as findings from the most recent NHS Staff Survey which took place in Autumn 2023.

Metric	CNTW Figures for Latest Reporting Period			CNTW Figures for Previous Reporting Period			2024 Trend
	Disabled	Non-Disabled	Comments	Disabled	Non-Disabled	Comments	
Overall workforce	723	6601	Disabled staff 8.9% of total workforce	648	6334	Disabled staff 8.2% of total workforce	Disabled workforce has increased.
Non-Clinical Band 5 or below	134 (85.9%)	979 (77.1%)	10% of non-Clinical staff are disabled	85.6%	80.1%	9% of non-Clinical staff are disabled	There are more non-clinical disabled staff at Band 5 or below than non-disabled staff.

Clinical Band 5 or below	267 (49%)	2495 (49%)	8.7% of Clinical staff are disabled	50.9%	48.1%	8.1% of Clinical staff are disabled	The ratio of disabled and non-disabled clinical staff is similar.
Medical consultant grade	12 (54.5%)	154 (61.8%)	3% of Medical staff are Disabled	58.8%	61.8%	6.2% of Medical staff are Disabled	There are more non-disabled staff at Consultant Grade.
Staff Appointed from Shortlisting	84 (600 shortlisted)	933 (4766 shortlisted)	Non-disabled staff are more likely to be appointed from shortlisting (1.398)	58 (647 shortlisted)	680 (14022 shortlisted)	Disabled staff are more likely to be appointed from shortlisting (0.54)	Non-disabled candidates are more likely to be appointed, compared to last year where disabled candidates were more likely to be appointed.
Staff entering formal capability process	No figures available for 2024.			No figures available for 2023.			
% Staff experiencing bullying, harassment or abuse from patients, relatives or public	28.26%	24.39%	3.87% point disparity gap	30.5%	25.7%	4.8% point disparity gap	Improvement for disabled staff over the last 3 reporting periods. The disparity gap has also decreased.
% Staff experiencing bullying, harassment or abuse from manager	8.19%	4.49%	3.7% point disparity gap	8.1%	4%	4.1% point disparity gap	The figures remain similar to the last reporting period, with a slight decrease in the disparity gap.
% Staff experiencing bullying, harassment or abuse from colleagues	16.77%	10.42%	6.35% point disparity gap	15.8%	9.5%	6.3% point disparity gap	Slight increase for both disabled staff and non-disabled staff.
% Staff or colleagues reporting bullying, harassment or abuse at work	65.26%	71.96%	6.7% point disparity gap in favour of disabled staff	71.8%	70.1%	1.7% point disparity gap	Fairly significant decrease for disabled staff and disparity gap in favour of disabled staff.
% Staff believing organisation provides equal opportunitie	59.98%	65.03%	5.05% point disparity gap	63.7%	61.6%	2.1% point disparity gap	Fairly significant decrease for disabled staff, with slight improvement

s for career progression							for non-disabled staff. The disparity gap has widened.
% Staff who felt pressure from manager to work, despite not feeling well enough	17.27%	10.23%	7.04% point disparity gap	18.1%	11%	7.1% point disparity gap	Improvement for both disabled and non-disabled staff. the disparity gap remains around 7%.
% Staff satisfied with extent that Organisation values their work	44.08%	51.76%	7.68% point disparity gap	44.6%	54.1%	9.5% point disparity gap	Slight decrease for both disabled and non-disabled staff, however the disparity gap has improved.
% Staff with long-lasting health condition or illness saying employer has made adequate adjustment(s) to carry out their work	81.04%	N/A		81.9%	N/A		Slight decrease following an improvement in 20-21 and 21-22 reporting periods. The figure has remained around 81% for the past three years.
% Trusts Board Membership Compared to Overall Workforce	7.1%	92.9%	Compares with 8.9% overall Disabled workforce	7.1%	92.9%	Compares with 8.2% overall Disabled workforce	

Key Findings

- The number of disabled applicants appointed from shortlisting has increased by 45% this year, with an increase of 37% for non-disabled applicants.
- Shortlisting of disabled applicants decreased by 3% this year and increased by 29% for non-disabled applicants.
- Disabled staff make up 10% of the overall non-clinical workforce, yet 85.9% of disabled non-clinical staff are in band 5 or below. This is compared to 77.1% non-disabled staff being in band 5 or below. The disparity between disabled and non-disabled staff at band 5 or below has increased from 5.5% points to 8.8% points compared to last year.
- Disabled staff make up 3% of the overall medical workforce and 54.5% are at Consultant Grade. This compares to 61.8% of non-disabled staff and therefore there are more non-disabled staff at Consultant Grade than disabled staff. The disparity between disabled and non-disabled staff at Consultant grade has increased from 3% points to 7.3% points compared to last year.
- There has been a marginal increase in both disabled and non-disabled staff experiencing bullying, harassment or abuse from colleagues. The disparity

between the experience of disabled and non-disabled staff remains around 6.3% points.

- According to the NHS Staff Survey 2023, there has been a significant decrease in the reporting of bullying, harassment or abuse at work for disabled staff. There is a 6.7% point disparity between disabled and non-disabled staff with non-disabled staff reporting higher levels of bullying, harassment or abuse at work.
- According to the NHS Staff Survey 2023, the number of disabled staff believing the organisation provides equal opportunities for career progression has decreased by 3.72% points, while increasing by 3.43% points for non-disabled staff. The disparity gap has widened.
- The NHS Staff Survey 2023 reported that there was a slight decrease for both disabled and non-disabled staff being satisfied with the extent the organisation values their work, however the disparity gap has improved.
- The percentage of disabled staff reporting in the NHS Staff Survey that the organisation has made adequate adjustments to carry out their work has remained around 81% for the last three reporting periods.

Actions

- Continue work to address progression opportunities for staff as part of agreed Trust Equality Objectives.
- Relaunch Give Respect Get Respect in conjunction with a research study into the experience of bullying in collaboration with the National Institute for Health and Care Research and with the Trust Research Innovation and Clinical Effectiveness team. The study will be informed by evidence-based research and will propose interventions that will be designed to reduce incidences and disparity between experiences in relevant WDES Metrics.
- Introduce a campaign for 'My Equality and Diversity' reporting within the Electronic Staff Record (ESR). The aim of the campaign will be to encourage staff to update their disability status within ESR, which will also contribute towards data collection for disability pay gap reporting.
- Establish an EDI dashboard and run quarterly checks on data to pinpoint any areas of concern.
- Measure the impact of the Reasonable Adjustments Toolkits for Managers and Staff.
- Work towards becoming a level 3 (highest level) Disability Confident Employer. Work to take place in conjunction with Disabled Staff Network and to be completed before the next Disability Confident validation in 2026.

Gender Pay Gap

The gender pay gap shows the difference in the average pay between all men and women in the workplace. This is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs, or work of equal value.

This report fulfils the Trust's legislative requirements and sets out what the Trust is doing to close the gender pay gap. The figures for the 6 metrics we are required to report on for 2023-2024 (based on 31 March 2024 snapshot) are as follows:

- Mean gender pay gap is 9.90% - a decrease of 1.66% points on 2022-2023.

- Median gender pay gap is - (minus) 2.29% - This indicates that the median hourly rate of pay for women (£17.16) is now greater than for men (£16.78).
- Percentage of men receiving bonus pay is 1.47% (2.0% previous year) and women 0.36% (0.5% previous year).
- Mean (average) gender pay gap using bonus pay is 11.88% - up from 10.99% in 2022-2023.
- Median gender pay gap using bonus pay is 45.77% up from 39.35% in 2022-2023.

Percentage of men and women in each hourly pay quartile

	CNTW Figures for 2023-2024		**CNTW Figures for 2022-2023**		**CNTW Figures for 2021-2022**	
	Male	Female	Male	Female	Male	Female
Top quartile	27.08%	72.92%	26.83 %	73.17%	27.7%	72.3%
Upper middle	20.40%	79.60%	19.79 %	80.21%	20.0%	80.0%
Lower middle	27.05%	72.95%	26.03 %	73.97%	27.4%	72.6%
Lower quartile	22.91%	77.09%	20.84 %	79.16%	19.3%	80.7%

Actions we have taken and continue to take to close the gender pay gap

- Commitment to paying the UK Living Wage: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust became an accredited Living Wage Employer in 2013. We were the first NHS Trust in the North-East of England to accredit with the Living Wage Foundation and have continued to champion the Living Wage during Living Wage Week each November. The Real Living Wage is worked out independently and takes into account rising bills and costs. Paying a Living Wage means that all staff are appointed on at least Band 2 of the Agenda for Change pay scales for NHS staff.
- Encouraging flexible working: the Trust promotes a supportive and flexible working culture. We recognise that flexible working helps employees to achieve a better balance between their work and home life, as well as improve service delivery through a flexible workforce. It can help the Trust become an employer of choice, aid recruitment and retention, reduce sickness absence and improve employee engagement, leading to an improved patient experience.
- Inclusive recruitment: the Trust has undertaken a substantial piece of work examining our recruitment processes, with the objective of removing any barriers to entry by protected characteristics as defined by the Equality Act 2010. Most of the measures we have adopted have been implemented. The next key piece of work that follows on from this will be a review of job descriptions. As part of this we will carefully examine and remove any gender bias that may affect the numbers of men and women applying for jobs with the Trust.

- Continue with Springboard for Women Programme: across society, the NHS, and here in the Trust, people who identify as having a protected characteristic tell us they do not always have the same opportunities as others to learn, develop and progress. Springboard for Women, one of several development programmes offered by Springboard Consultancy, provides women with the inspiration, tools and confidence boost to enable them to choose what they want to do and to take their next steps (at work, in life) when the time is right for them.

Actions we plan to take to close the gender pay gap

- Mend the Gap Recommendations: we will in 2025-2026 continue to address the actions against Mend the Gap report to ensure that we are doing all we can to address pay gaps for Doctors.
- Address Intersectional Issues: as part of our response to the EDI Improvement Plan, we will produce our first Race Pay Gap report and will begin to collect data to look at the gaps for other protected characteristics. We will compare the results of these to the Gender Pay Gap and examine if there are intersectional issues which we need to address. Such work will also help inform our key EDI objective of progression for staff who share protected characteristics. We will triangulate these results with the Gender Pay Gap and figures for our other mandatory Equality and Diversity Workforce Reports.

Give Respect Get Respect

During this year we relaunched the Trust's Give Respect Get Respect Campaign. It is designed to encompass all of the activities that we do towards Equality, Diversity and Inclusion under one over-arching campaign. When we're respected by others it helps us to feel safe and we can be our true selves. Respect means that we accept each other, even when people are different from you, or you don't agree with them. Respect builds feelings of trust, wellbeing and safety.

Give Respect Get Respect underpins our Trust values. At CNTW, we are:

Caring and compassionate...
Because that is how we'd want others to treat those we love.

Respectful...
Because everyone is of equal value, is born with equal rights and is entitled to be treated with dignity. We want to protect the rights of future generations and the planet that sustains us all.

Honest and transparent...
Because we want to be fair and open, and to help people make informed decisions.

Workforce Bullying Evaluation

As part of the relaunch of Give Respect Get Respect, an opportunity arose to collaborate with the Directorate of Research Innovation and Clinical Effectiveness alongside a research associate from the National Institute for Health and Care Research to evaluate staff experiences of bullying. The survey was designed to focus solely on bullying. This differs from the National NHS Staff Survey which combines bullying, harassment, and abuse into one question. It was agreed to include a clear definition of what behaviours amount to bullying as this is something that is not defined in the national survey.

The survey ran over August-September. Over 1300 staff completed the survey with many insights and themes emerging from the analysis.

Round table discussions of these themes took place in December 2024 with Executive Directors and the Trust Leadership Forum – where the Trust's senior leaders come together to discuss key initiatives and priorities.

The Equality, Diversity and Inclusion Team continue to engage with our Senior Leaders, Staff Networks and research colleagues to ensure these important discussions continue to take place.

Reasonable Adjustments Toolkit for Staff and Managers

To keep supporting disabled staff, last year the Trust began work to develop a set of resources to help disabled staff and their managers with the process of making reasonable adjustments at work. This officially launched on 13 May 2024 during NHS Employers Equality, Diversity & Human Rights Week.

These toolkits make it clear how to ask for help, what managers need to do, and where to get more advice. To develop them, we held meetings with staff, worked in focus groups, and got feedback through different forums.

Our goal was to make sure the toolkits fit with the law and our own Trust values of equality. It is vital that we make sure our staff get what they need to help them carry out their work comfortably, safely, and effectively. Not only is this our legal duty and important for people's own wellbeing, but it also helps us to retain staff.

As well as a toolkit with advice for disabled staff, we developed a toolkit specifically for managers, because we felt it was important to make sure managers know what they need to do when someone asks for help. Managers must support their team members, both during and after making these changes.

Choices College

Choices College (formerly Project Choice) is a specialist College providing tailored educational support, and a supported internship course for young adults aged 16-24 who are autistic and/or have learning difficulties/disabilities.

This is a partnership programme, which means that Choices College support coaches and coordinators who ensure the students are well supported throughout their internship. Teams who accepted placements were offered mentor training (tailored to the students they hosted) as well as ongoing support from Choices College area managers. The internships typically last 10-12 weeks and can be as flexible as necessary to best suit the interns and the needs of the service. During the year we have supported 14 students gaining valuable work experience across a range of teams within the Trust and NTW Solutions.

Here's what some of our students had to say:

Jake (Neurorehabilitation Outpatients) said:

"I have enjoyed learning about RiO and how it works. I feel supported by my mentor on the work placement, and I have learned a lot about being in a work environment."

Callum (Catering) said:

"I have liked meeting the staff and trying different things out. I have enjoyed learning how to make up the ward trolleys. I like my uniform and would like to keep it!"

Ben (Volunteer Team) said:

"I have definitely enjoyed working on everything so far. I have enjoyed working with the team. They are all really nice."

We are really looking forward to celebrating their graduation this year and welcoming a new cohort of students in September.

New Trauma-Informed Health, Wellbeing and Attendance Policy

CNTW's new Health, Wellbeing and Attendance Policy went live in March 2025. This replaces the Managing Sickness Absence Policy.

The new policy was written in collaboration with a broad range of colleagues across the Trust, including Workforce and Organisational Development and the Disabled Staff Network.

It is the first workforce policy to be written through a trauma-informed lens. To deliver trauma-informed services to our patients, it's important to support our staff using the same principles.

Staff Networks

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

The following sections provide highlights of staff network activities during 2024-25:

Cultural Diversity Staff Network

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

Notable events hosted by the network this year:

- Cultural Diversity Network Book Club
- Black History Month – Reclaiming the Narrative
    - Virtual event with guest speakers from CNTW's workforce
    - Themes menus in Trust cafés

    - History, arts, and healthcare exhibition event
    - Wear Red Day
- South Asian Heritage Month
    - Virtual event with guest speakers from staff in different professions who are from South Asian backgrounds

Disabled Staff Network

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

Notable events hosted by the network this year:

Disability History Month Ableism Campaign and Lunch and Learn Sessions

- Internalised Ableism & I
- Unlearning Ableism
- Let's Talk About Ableism
- Ableism – Everyone's Business
- The Autistic Advocate
- Disability Rights
- Disability and Reasonable Adjustments

LGBT+ Staff Network

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

Notable events hosted by the network this year:

- LGBT+ History Month
    - LGBT+ and Medicine
    - Gender: Past, Present and Future
    - LGBT+ Over the Years
    - Neuro Diversity and the LGBT+
- Trans Day of Remembrance
- Pride
    - Pride Party Packs and resources
    - 'Our Authentic Selves' video campaign

Armed Forces and Veterans Network

The group aims to ensure the Trust provides support to staff who are connected with the armed forces. It is key to helping the Trust fulfil its duties under the Armed Forces Covenant and the requirements of being a Veterans Aware organisation. CNTW is accredited as a Veteran Aware Trust and holds a Gold Award under the Defence Employer Recognition Scheme.

Notable events hosted by the network this year:

- Armistice Day
    - Breakfast club event
    - Chapel service
- Armed Forces Day – Gregg Stephenson's story

Contact Details

For further information about any of the items in this report or any queries you may have please email equality@cntw.nhs.uk and the Equality Diversity and Inclusion team will be pleased to assist you.

4.3 RAISING CONCERNS / WHISTLEBLOWING REPORT

Lynne Shaw, Executive Director Workforce and OD

REFERENCES

Only PDFs are attached

4.3 Raising Concerns Report October-March2025.pdf

Meeting	Trust Board of Directors		**Agenda item: 4.3**
Date of meeting	Wednesday 23 July 2025		
Report title	Raising Concerns / Whistleblowing Report		
Report Lead	Lynne Shaw, Executive Director of Workforce and Organisational Development		
Prepared by	Gemma Pattinson, Deputy Director of Workforce and Organisational Development		
Purpose	**For decision**	**For assurance**	**For awareness**
			X
Report previously considered by	People Committee (June 2025)		
Executive summary	The purpose of this paper is to provide a summary of whistleblowing cases/concerns raised over the period from 1 October 2024 to 31 March 2025. 65 issues have been raised in total with 59 of those via the Freedom to Speak Up Guardians and 6 via the Care Quality Commission. This is an increase from the previous period but consistent with the same time last year. Bullying and management processes remain the areas with the highest number of cases.		
Detail of corporate/ strategic risks	SA3 – 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	Board of Directors is asked to note the content of this report in line with national requirements. The People Committee has discussed the detail of the report at its meeting in June 2025, at which two of the Guardians were present.		
Supporting information / appendices	N/A		

Trust Board of Directors
Wednesday 23 July 2025

Raising Concerns/Whistleblowing Report

1. Executive Summary

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

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

Give respect
Get respect

Everyone deserves respect and work should be a safe space for everyone. All concerns are taken seriously, and staff can raise concerns via line managers, Workforce, Trade Union representatives and Freedom to Speak Up Guardians. Support is offered via the Regional Wellbeing Hub, staff networks and support groups as well as the Trust Occupational Health service, Optima.

During the period identified, 65 issues have been raised via the FTSUG (59) CQC (6). This is an increase compared to the previous period (39). The six CQC concerns related to:

- Northumberland Recovery Partnership (October 2024) related to partner Human Kind
- North Cumbria Community Treatment Team (October 2024)
- Recovery and Treatment Service Plummer Court (October 2024)
- Sexton House (November 2024)
- EIP team Northumberland (March 2025)
- Carleton Clinic (March 2025)

There is a trend in cases linked to Management Processes and Bullying. Management Processes mirrors the previous report however we have noted bullying as the highest reason for FTSUG concerns.

2. Position Update

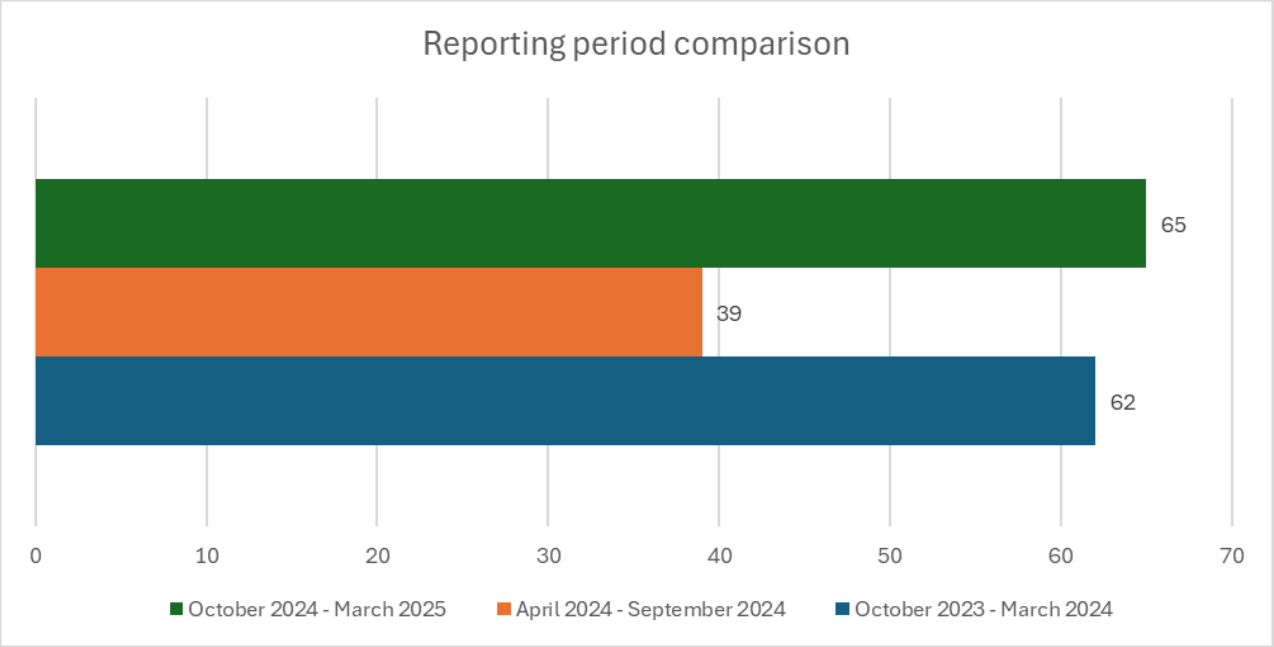
The Trust has had for a number of years a clear, defined process for recording cases that fall under the scope of a policy such as whistleblowing (raising concerns), disciplinary or grievance, however, there are a number of concerns raised which do not meet the Disclosure Act's definition of whistleblowing.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

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

Summary of Cases Logged Centrally and with FTSUG for the period 1 October 2024 – 31 March 2025

Theme	FTUG	CQC
Bullying	10	
Management Process	9	
Safety concerns	7	2
Unknown	5	
Behaviour	4	2
Leadership	4	
Management behaviour	3	
Rotation	2	
VISA changes	2	
Management response	2	
ESR recording	1	
Annual leave	1	
Working Arrangements	1	
Fast track process	1	
Culture	1	
Confidentiality	1	1
Harassment	1	
Fairness of allocation	1	
Workload	1	
Relationship	1	
Poor Service		1
Flexible Working	1	
Grand Total	**59**	**6**

The graph below shows that in comparison to the previous reporting period the total number of concerns raised has increased.



The Speaking Up follow up process has been strengthened with monthly meetings between the Group Heads of Workforce, Deputy Director Workforce and OD and Freedom to Speak Up Guardians. These meetings ensure that timely action is taken for concerns raised.

During this reporting period there has been the changeover of the Freedom to Speak up Guardians. Following a recruitment exercise four new Freedom to Speak up Guardians commenced role in January 2025.

The Freedom to Speak Up policy has been reviewed in March 2025, this policy is a nationally adopted policy, however, does give the information on who to speak up to in the Trust.

A FTSU internal audit was undertaken in quarter three of 2024 key actions have been identified including the review of data capture, capturing feedback via feedback questionnaire and communications strategy.

Areas where concerns have been raised (FTUG cases)

Area	Number
Community South/Central	19
Inpatient	13
Specialist	9
Community North (includes N Cumbria)	6
Unknown	4
NTW Solutions	3
Bank	3
Corporate	2
Grand Total	**59**

3. Themes

Management Process

Mirroring the previous report, many of the concerns raised regarding Management Processes (policies and procedures) are linked to employee relations processes. The main reason for concerns raised is where an employee is not in agreement with a disciplinary process being undertaken, the timeliness of investigations or being placed on alternative duties while an investigation is ongoing.

Work continues as previously reported on triaging employee relations cases. Monitoring of employee relations cases is via Business Delivery Group – Workforce.

During the reporting period the Trust has reviewed the grievance policy in partnership with stakeholders. This policy is now a Resolution policy and focuses on resolving issues at the earliest possible stage, being clear on outcomes and utilisation of tools including respectful resolution.

Behaviours (including bullying)

Behaviour continues to be a theme with the behaviour of management/supervisor being highlighted; this includes concerns regarding lack of support as well as unfair treatment. Under this umbrella of behaviour, it can also include the theme of bullying and harassment. Not all cases are escalated, however, and in most instances the Freedom to Speak up Guardians support and coach staff members to address concerns locally.

In the reporting period, the Trust has rolled out the Leadership programme which focuses on compassionate leadership and culture. The key modules have already been delivered to members of Trust Leadership Forum as well as several other cohorts which have evaluated well.

Role of Guardians

The Freedom to Speak Up Guardians have sought to help staff resolve issues themselves without them having to escalate the issue. This is through encouraging conversations to take place with managers in line with the Raising Concerns policy, signposting staff to utilise existing processes and support mechanisms available or providing some confidence and reassurance to staff.

In terms of national updates there is a new Job Description for Guardians which was released at the end of May 2025.

Locally, a cleanse of the 94 champions has been undertaken and the Trust currently has 37 active champions who regularly attend meetings and proactively engage.

In terms of gathering feedback, there is a recent FTSUG survey which is available via the Trust bulletin and on the internet which aims to gather the views from staff, including the awareness of speaking up and whether staff are comfortable approaching the Guardians and raising concerns. The results of this survey will be outlined in the next bi-annual report.

The Communications team continues to raise the profile of speaking up and raising concerns. A refreshed communications plan is being established. The Guardians have also planned a number of site visits.

Our FTSUGs confirm that over the period of the report the themes as described above remain similar to previous reporting periods.

There continues to be regular meetings with the FTSUGs and the Executive Director of Workforce and Organisational Development to discuss themes and escalate any cases that need support to resolve.

Gemma Pattinson
Deputy Director Workforce & OD
6 May 2025

Lynne Shaw
Executive Director Workforce & OD

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 Board Committee Assurance Report - RBAC - June 2025 final.pdf

Report to the Board of Directors
Wednesday 23 July 2025

Resource and Business Assurance Committee Quarterly Assurance Report

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 (RABAC). This includes an overview of the areas of focus, discussion and assurance.

2. Resource and Business Assurance Committee overview

The Committee receives assurances 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. It examines current and emerging risks to delivery, the effective and efficient use of resources, and the long-term sustainability of the Trust.

There has been one meeting of the Committee during the period May 2025 – July 2025, this meeting was held on 20th June 2025.

3. Board Assurance Framework risks within Committee remit

The Resource and Business Assurance Committee is currently managing the following key risks on the Board Assurance Framework (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

The risks are considered as part of the regular system of review. 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 details of Trust plans on behalf of/or prior to the board. (e.g. West Cumbria service developments)

We continue to receive regular updates on the CEDAR programme (including NHP updates), utilities reports, ERIC (Estates Return Information Collection), PLACE (Patient Led Assessment of the Care Environment) and PAM (Premises Assurance Model) reports. All performing satisfactorily to date. 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 summer 2025 completion date on track

4. **Other issues and assurance received by the Committee**

Finance

Assurance around the financial position is predominantly received through the finance report which covers overall compliance with in-year control totals, performance against capital programme and CDEL allocation, cash management and delivery of any efficiencies. Reports have been timely and provided a good level of detail for assurance

Whilst control of in year performance is always reported on, there is increasing focus on medium and long-term planning for sustainability. Increased emphasis will be on financial forward planning as well as looking at our overall WTE usage as an organisation in relation to our evolving Model of Care and Support, being the key driver of costs within the Trust. In addition, we have looked at corporate efficiencies, and service changes 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.

Digital

The committee reviewed our Digital maturity assessment including a joint peer review with TEWV. The Trust's average score this year is 2.1 out of 5, indicating a stable digital foundation but with room for clear areas of improvement. We have also reviewed a draft Terms of Reference for a new digital committee which will stand alone from RBAC. Further work is ongoing.

Provider Collaborative

The Committee continues to provide oversight of the Provider Collaborative. The reporting of these issues has evolved to a more integrated approach to ensure oversight of the collaborative as a whole rather than individual contract aspects considered separately.

Each RABAC considers the BAF risk exception report in the context of the updates and reports provided during each committee.

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.

Brendan Hill
Resource and Business Assurance Committee Interim Chair
July 2025

5.2 FINANCE QUARTERLY REPORT (QUARTER 1)

Chris Cressey, Interim Executive Director of Finance

REFERENCES

Only PDFs are attached

5.2 2526 - BoD - M3 Finance Update.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Wednesday 23rd July 2025**
Title of report	**Month 3 Finance Report**
Executive Lead	**Chris Cressey, Interim Director of Finance**
Report author	**Chris Cressey, Interim Director of Finance**

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

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

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

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

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
2545 – Failure to deliver sustainable financial position, 1687 – Managing resources effectively, 1762 – Restrictions in capital expenditure

Month 3 Finance Report

1. Executive Summary

1.1 At Month 3 the Trust has generated a **£2.9m surplus.**

1.2 This surplus is **better than the financial plan at Month 3 by £4.1m** due to the receipt of proceeds from the sale of land at Northgate. Without the land sale proceeds the trust would be £3.1m behind plan.

1.3 This plan is phased to deliver deficits in the first 9 months of the year and surpluses for the last quarter of the year as the land sale is planned for Q4 and greater efficiency is phased towards the end of the year.

1.4 The trust is forecasting to deliver the planned £3.3m surplus for financial year 2025/26.

1.5 The trust has identified up to £6.7m of risks against delivery of the plan but has also identified a number of mitigations to those risks. The trust is finalising financial recovery plans with services where they are experiencing staffing pressures against budgets in 2025/26.

1.6 At the end of Month 3 the Trust has spent **£2.2m on agency staff against a plan £1.5m.**

1.7 **WTEs have reduced by 49 since June 2024 but staffing budgets are over established at month 3 against the trust plan.**

1.8 Expenditure on **the Trust capital programme is forecast to deliver against plan.** The Trust submitted a plan compliant with the CDEL limit allocated to the Trust and plans to deliver within the CDEL limit.

1.9 The Trust has a **cash balance of £27.5m** at the end of Month 3 which is ahead of the plan due receipt of the land sale proceeds.

2. Month 3 Report – Key Issues

2.1 The Trust provided a finance return to the ICB reporting a positive variance from plan of £4.1m year to date at month 3 and delivery of a planned surplus of £3.3m. The return showed deliver of £30.6m efficiency, the total included in the Trust plan.

2.2 The Trusts positive year to date position includes the benefit from the sale of land at Northgate, phased into the plan towards the end of the year. Removing the benefit the trust is £3.1m behind plan

2.3 The Trust has identified financial pressures across a number of staffing budgets through Q1. Budgets have been over established throughout the quarter. The table below show the over establishment has reduced month on month, but the trust remains 36 over established at the end of the month. The table below shows the over establishments across the trust:

	Month 3			Month 2	Month 1
	Budget	Actual	Variance	Variance	Variance
	WTE	WTE	WTE	WTE	WTE
Inpatients	1,817	1,870	53	63	107
Community	3,041	3,037	(5)	(9)	24
Specialist	1,887	1,939	51	81	114
Infrastructure	1,849	1,785	(73)	(65)	(40)
TOTAL	**8,594**	**8,630**	**36**	**70**	**205**

All groups have reduced the pressure from Month 1, but the Trust remains over established. The trust is behind the planned monthly budget therefore to meet the financial plan will need to go further to catch up to the financial plan.

The table below shows the actual WTE reported by the trust at the end of each quarter over the last 12 months. The total WTE has reduced. The reduction has predominately come in inpatients, although despite this, inpatients remain behind plan. The trust plan was predicated on Community maintaining spending levels seen in 24/25 and Specialist delivering to budget. Both areas have seen increases in WTE since June 25.

	June 24	Sept 24	Dec 24	Mar 25	June 25	June to June
	WTE	WTE	WYE	WTE	WTE	WTE
Inpatients	1,984	1,970	1,939	1,942	1,864	(120)
Community	2,982	2,970	2,992	3,040	3,037	54
Specialist	1,907	1,879	1,910	1,955	1,939	32
Infrastructure	1,806	1,798	1,820	1,820	1,791	(15)
TOTAL	**8,679**	**8,618**	**8,660**	**8,759**	**8,630**	**(49)**

The trust is finalising financial recovery plans for all services operating above their staffing budgets. The Resource & Business Assurance committee will scrutinise the financial recovery plan and the plans will be managed through the trust's executive led 'Well Led' meetings.

2.4 **OATs -** The trust experienced a spike in out of area patients through April. The position has been redressed. The pressure from April reflects the Trusts finance pressures year to date and forecast.

2.5 **Efficiency -** The trust has reviewed the efficiency programme and is forecasting to deliver the full £30.6m planed efficiency. The review has identified some recurrent schemes incurring slippage in year. To offset the slippage the trust has identified non recurrent mitigations to maintain delivery of the efficiency at planned levels. The table below shows the pressures in the planned programme and the mitigations: -

	Pressure		Mitigation
	£m		£m
Secure Services in Deficit	3.0	Investment Income	(1.1)
Inpatient staffing pressures	2.0	Manage Vacancies	(2.1)
CYPS Services in Deficit	0.7	Manage Financing Costs	(1.2)
Unidentified Efficiency	2.1	Non-Pay Management	(3.4)

TOTAL	**7.8**		**(7.8)**

The recurrent schemes are still expected to deliver into 2026/27 and will support reduction of the underlying financial gap.

2.6 **Temporary Staffing –** The NHS requires providers to reduce agency spend from 2024/25 by 30% and bank spend by 10%. The table below shows the targets for CNTW and the forecast annual spend. To deliver financial recovery all areas must deliver the nationally allocated temporary staffing targets to support financial delivery within budgets.

	Agency 24/25 (less 30%)	Agency forecast 25/26	Diff	Bank 24/25 (less 10%)	Bank forecast 25/26	Diff
	£'000	£'000	£'000	£'000	£'000	£'000
CNTW	6,361	7,482	1,120	14,477	15,932	1,455

2.7 **Risk** – The table below shows the pressures included in the trust forecast at month 3 and how the trust is planning to mitigate these pressures.

	£m
Staffing pressures	2.6
Patients clinical ready for discharge	2.8
OATS pressures	0.7
NTW Solutions pressures	0.4
Shortfall on gain on disposal	0.2
Identified Risk	**6.7**
Staffing Recovery – Temporary Staffing target	(2.6)
Financial recovery - Inpatients	(2.9)
Manage Non-Pay Programmes	(1.2)
Mitigations	**(6.7)**

2.8 The Trust has submitted a financial return at month 3 showing delivery of the planned £3.3m surplus but is discussing the risks in the plan with the ICB.

2.9 **Underlying Position** – NHS England require all provider organisations to submit the underlying financial position as part of the month 3 return. CNTW has submitted a £33m underlying financial gap.

2.10 **Capital** - The trust is planning full delivery of the approved capital programme.

2.11 In 2025/26 the NHS have delegated the capital allocation for IFRS16 (leases) to ICBs, having previously held it centrally. The allocation has then been passed to providers and is included in capital programmes this year. CNTW have included the forecast the impact of any new, remeasured and disposed leases. Any changes to the lease position will impact on the plan to deliver the capital programme.

2.12 **Cash -** The Trust has a cash balance of £27.5m in June, which is ahead of plan due to the receipt of the funds from the land sale.

3. Recommendation

3.1 The Board are asked to;

a. Note the current financial position of the Trust reported at month 3.
b. Note the Risk & Mitigations position based on the financial recovery plan to understand the risk in the Trust forecast to deliver the planned £3.3m surplus in 2025/26.
c. Note the capital and cash position at month 3.

5.3 NHS 10 YEAR PLAN

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

5.3a NHS 10-year plan and Neighbourhood Health - CNTW approach v2.0.pdf

5.3b. NHS 10 Year Plan slides with Strategy and MoC slides.pdf

Meeting	**Board of Directors**		**Agenda item: 5.3**
Date of meeting	Wednesday 23 July 2025		
Report title	NHS 10-year Health Plan and Neighbourhood Health		
Report Lead	James Duncan – Chief Executive Officer		
Prepared by	Tommy Davies – Deputy Director of Transformation, Delivery and Performance		
Purpose	**For decision**	**For assurance**	**For awareness**
		x	
Report previously considered by	None		
Executive summary	**NHS 10-Year Plan and Neighbourhood Health Update** The NHS 10-Year Plan has now been published. This report and accompanying presentation provide an overview of its key priorities, with particular emphasis on the Neighbourhood Health agenda, which is a central theme in the plan. The Trust continues to be actively engaged in local Place-based discussions with system partners, focusing on using population health data to identify priority areas and develop integrated, patient-centred approaches. The report also includes a brief update on progress with 24/7 Neighbourhood Health Centre pilot initiatives, including the Hope Haven pilot in West Cumbria.		
Detail of corporate/ strategic risks	**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 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.		
Recommendation	• Review the update on the NHS 10-year plan and Neighbourhood Health and the developments across the Trust. • The board may want to consider this in depth at a future planning session		
Supporting information / appendices	Supporting slide presentation		

NHS 10-year Health Plan and Neighbourhood Health

Contents

10-year Health Plan Summary of key areas

1. **From Hospital to Community -** more convenient and care closer to home

- Shift care delivery from hospitals to **neighbourhood, community, and primary care settings**.
- Expand local multidisciplinary teams and support more care at or closer to home.
- Specifics:
  - Easier access to a **GP** – virtual consultation within 24 hours
  - New **Neighbourhood Health Centres** in every community
  - Quicker **specialist** referrals
  - **Mental Health** A&Es

2. **From Sickness to Prevention –** More help to stay healthy

- Invest in **early intervention**, prevention, and addressing **health inequalities**.
- Focus on improving the wider determinants of health and reducing demand through proactive care.
- Specifics:
  - Making **healthier choices easier**
  - Banning **energy drinks** for under-16s
  - New **weight loss services**
  - Home **screening kits** for cervical cancer
  - More **support to low-income** families

3. **From Analogue to Digital –** more power in patients' hands

- Accelerate use of **digital tools, data, and technology** across the system.
- Enable better access, remote monitoring, personalised care, and population health management.
- Specifics:
    - A new and intuitive **NHS App**
    - **Single patient record**
    - **Digital red book** to manage children's health
    - **Online booking** for appointments
    - Staff **liberated from bureaucracy**

Key areas from the 10-year plan for Mental Health, Learning Disability and Neurodivergent services

Child & Adolescent Mental Health

- Expansion of Mental Health Support Teams (MHSTs) in schools and colleges, reaching national coverage by 2029–30 to strengthen early intervention
- Young Futures Hubs embedded within educational settings to ensure seamless access for children and young people, closing the front-door gap
- Recruitment of an additional 8,500 mental health professionals, targeting reduced wait times and improved access for both children and adults

Crisis, Emergency & Urgent Mental Health Care

- £120 million investment to develop 85 dedicated Mental Health Emergency Departments (MHEDs) with same-day care facilities
- Enhanced ambulance triage and crisis response, redirecting appropriate cases away from general A&E and ensuring specialist care.

Neighbourhood Mental Health Hubs

- Integration of mental health services into neighbourhood health centres, moving care away from hospitals into local community settings.
- A strategic shift from hospital to community care as a core pillar of the plan

Prevention, Wellbeing & Digital Support

- Holistic prevention-first approach, including mental health support in schools, healthier schools initiatives, and digital tools to encourage early help-seeking.
- NHS App modernisation to include virtual therapists, easier access to mental health resources, care plans, and self-referral options.

Inpatient Mental Health as a Last Resort

- Hospitals and inpatient services positioned only as a last resort, with a clear emphasis on community and crisis alternatives.

Learning Disability and Neurodivergent services

- The has very little with regards to any detail on these services

CNTW ambitions and model of care with key areas linked to the 10-year Health Plan

The below set of ambitions are a core part of the Trust Strategy – With you in mind. Each ambition is highlighted where there are strong links with the 10-year plan. The Trust ambitions and Model of Care demonstrate Trust we are already committed to delivering across the three big shifts and the key areas described in the 10-yr plan.

With you in mind - Our Strategy from 2023 – Ambitions:

Ambition 1: Quality care, every day - We will aspire to deliver expert, compassionate, ***person-led care every day***, in every team. We will value research and learning.

Ambition 2: Person-led care, when and where it is needed - ***We will work with partners and communities*** to support the changing needs of people over their whole lives.

Ambition 3: A great place to work - We want to be a great place to work. We will make sure that ***our workforce has the right values, skills, diversity and experience*** to meet the changing needs of our service users and carers

Ambition 4: Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and ***be digitally enabled***

Ambition 5: Working with and for our communities - ***We will create trusted, long-term partnerships that work well together to help people and communities.***

Model of care and support

Help and treatment for people with mental health and wellbeing needs, learning disabilities, neurodivergence, or neurological disorders.

Community treatment

Services for people in the community receiving evidence-based treatment.

Understanding you and helping you stay well

This will happen by closely working with:

You and your needs
Family, friends, carers, peers
Education
Voluntary sector
Social care
Work and activities
Housing and benefits
Primary care, GPs
Physical health
Other partners

Inpatient care

Services for people who require additional treatment within an inpatient setting.

Long term complex needs

Services for people in the community with severe mental health needs and other complex needs.

Urgent and crisis care

Services for people in the community with urgent needs.

NHS 10-Year Plan - Neighbourhood Health Summary

The plan sets out a major shift towards neighbourhood-based care, aiming to provide joined-up, personalised support within local communities. It promotes integrated multi-disciplinary teams that work across health, social care, and the voluntary sector to address physical, mental, and social needs holistically.

Neighbourhood Health focuses on early intervention and prevention, using population health data to identify priority groups and reduce health inequalities, particularly in deprived areas. The approach encourages greater collaboration with local authorities, voluntary and community organisations, and citizens, empowering people to manage their own health and wellbeing.

Investment in neighbourhoods is designed to reduce hospital admissions and reliance on specialist services by expanding community-based support, improving access, and building partnerships that address the wider determinants of health.

The **24/7 Neighbourhood Health Pilots** are part of the NHS's broader strategy to decentralise care and provide more accessible, community-based services. These pilots aim to deliver integrated, round-the-clock support for individuals with mental health needs, reducing reliance on hospital admissions and improving access to care.

Neighbourhood Health and 24/7 Neighbourhood Mental Health Centres - CNTW approach

The Trust is engaged at **Place** in some positive local discussions with partners about **Neighbourhood Health** which are progressing well, the key themes have been as follows:

- A focus on the **population health** data to inform priorities
- Choosing some **key areas of focus** that all partners can support such as Frail Elderly services
- Developing joint access to services and discussions about partner **hubs**
- Developing Multidisciplinary Team (**MDT**) working and meetings with services wrapped around our patients

There are six 24/7 Neighbourhood Mental Health Centre **Pilots** across the country. **Hope Haven** in Copeland, West Cumbria is one of them and is progressing well. The following provides a flavour of some of the progress that has been made:

- It is unique in investing the support wholly into the VCSE and wrapping CNTW teams around the VCSE and other partners
- Hope Haven is already delivering services in the community with partners working together

- A partnership wellbeing access hub will open in the middle of Whitehaven in the Autumn
- The Hub will have virtual access online, telephone access, email and walk-in, ensuring we can meet all people's needs
- There will be a single electronic solution to support people using the services that can be accessed by all partners so that sharing data and working collectively in a joined up person centred way is not hampered by technology and information governance

Other joined up care MDT/Hub development is continuing across other areas

- Newcastle have already gone live with The Space in a PCN which provides walk wellbeing support with partners working together to provide joined up care.
- Further work on partnership Neighbourhood Health is in progress with United Newcastle, building on some of the strong partnerships within the city to use resources collectively to support patients in a more collaborative way with patients at the centre of their care.
- Northumberland have been working together on a Collaborative Working Pilot that has involved the Trust and other partners and the mid stage evaluation has highlighted some of the valuable work happening there. The
- South Tyneside Primary Care Health Hub provides support for people with learning disabilities, autism ADHD, severe mental illness, and special educational needs and disabilities. It provides health checks, medication reviews, immunisations, and public health advice and support.
- Workington in West Cumbria are working together as a wider partnership of the council, GPs and Trusts to apply to be one of the Neighbourhood Health Centre Pilots that receives coaching support and pilot status.

Fit for the Future

The 10 Year Health Plan for England

July 2025

The three shifts

Hospital to community

- Easier access to a **GP** – virtual consultation within 24 hours
- New **Neighbourhood Health Centres** in every community
- Improved access to **dentistry**
- Quicker **specialist** referrals
- **Mental Health** A&Es

More convenient care closer to home

Analogue to digital

- A new and intuitive **NHS App**
- **Single patient record**
- **Digital red book** to manage children's health
- **Online booking** for appointments
- Staff **liberated from bureaucracy**

More power in patients' hands

Sickness to prevention

- Making **healthier choices easier**
- Banning **energy drinks** for under-16s
- New **weight loss services**
- Home **screening kits** for cervical cancer
- More **support to low-income** families

More help to stay healthy

With you in mind

Our strategy from 2023

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Long term complex needs

Services for people in the community with severe mental health needs and other complex needs.

Urgent and crisis care

Services for people in the community with urgent needs.

With YOU in mind

Neighbourhood Health and the 24/7 pilots

- The Trust is engaged at **Place** in local discussions with partners about **Neighbourhood Health** which is progressing well, the key themes have been as follows:
  - A focus on the **population health** data to inform priorities
  - Choosing some **key areas of focus** that all partners can support such as Frail Elderly services
  - Developing joint access to services and discussions about partner **hubs**
  - Developing Multidisciplinary Team (**MDT**) working and meetings with services wrapped around our patients

- 6 Neighbourhood Mental Health Centre **Pilots** across the country
- **Hope Haven** in Copeland, West Cumbria is one of them
  - It is unique in investing the support wholly into the VCSE and wrapping CNTW teams around this and other sectors
  - Hope Haven is already delivering services in the community with partners working together
  - A partnership wellbeing access hub will open in the middle of Whitehaven in the Autumn
- Other joined up care MDT/Hub development is continuing across other areas such as Newcastle

Significant changes

A new operating model

- Smaller, strategic centre and a rules-based system
- ICBs as commissioners
- Foundation Trust regime for autonomy
- Partnership with local government for neighbourhood health
- Multi-year budgets and outcomes-based payments

Transparency of quality

- Publish more information and rankings
- AI tools for complaints data
- Revitalised National Quality Board with mandate for measurement
- New quality strategy
- Provider flexibility for quality bonuses

Innovation

- 5 big technology bets – from the Future State work
- Global Institutes and Regional Health Innovation Zones
- Faster clinical trials
- Improved research environment
- Future proof regulators & single national formulary

What will be delivered by 2028/29?

While the plan is for the next 10 years, most of the plan will be delivered more quickly than this.

HOSPITAL TO COMMUNITY

- **Same-day digital and telephone GP appointments**
- **A GP led Neighbourhood Health Service**
- **Neighbourhood Health Centres in every community; increased pharmacy services and more NHS dentists.**
- **Redesigning outpatient and diagnostic services**.
- **Redesigning urgent and emergency care**
- **Care plans for people with the most complex needs by 2027** and the **number of people offered a personal health budget will have doubled.**
- **Patient-initiated follow-up will be a standard approach.**

ANALOGUE TO DIGITAL

- **The NHS App** will be the front door to the NHS
- **'HealthStore' to access approved health apps**
- **A Single Patient Record**
- **Digital liberation for staff**

SICKNESS TO PREVENTION

- **Health Coach will be launched**
- **New weight loss treatments and incentive schemes to help reduce obesity.**
- **The Tobacco and Vapes Bill will be passed, creating the first smoke-free generation.**
- **Women will be able to carry out cervical screening at home using self-sample kits from 2026.**

Mental Health – key messages

- Hospital to community will improve access to mental health services, bringing multidisciplinary teams closer to where patients live and work. It will also see the introduction of more mental health support teams in schools.

- Analogue to digital will create, and improve access, to digital technologies providing mental health support.

- Sickness to prevention will mean more people will be able to receive support for mental ill health much earlier by increasing the rollout of mental health services in school and introducing new Young Future Hubs.

Mental Health - key policies

- **A Neighbourhood Mental Health Model,** providing open access to specialist services and holistic support in community locations 24/7**.**
- **Assertive outreach** will be expanded to tackle mental health inequalities, reaching 100% national coverage within a decade.
- **85 new dedicated mental health emergency departments** will be built with £120 million, to ensure people experiencing crisis get effective care**.**
- **Patients will get better access to support directly through the NHS App,** including self-referral for Talking Therapies.
- **Digital access to mental health support and therapies** will mean patients no longer have to travel to hospitals or clinics outside of their local area**.**
- **The HealthStore** marketplace will host approved health apps to support people to manage their conditions, including mental health.

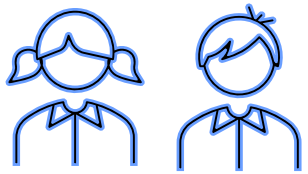
Mental Health - key policies

- **A single patient record**.
- **Support for people to remain in or return to work who are experiencing poor mental health**, and continue to expand provision of Individual Placement Support (IPS).
- **Collaboration** with businesses, investors, social enterprises, employers **to address the mental health crisis affecting children and young people,** and **roll out of Mental Health Support Teams in schools** with full coverage by 2029/30.
- **The My Children tool** will store information about each child in one place, replacing the red book, and the **New Young Futures Hubs** will ensure there is no “wrong front door” for people seeking help.
- **We will increase the proportion of funding of research into prevention and detection** of physical and mental long-term conditions, by reforming the NIHR and better promote a focus on prevention**.**

Learning disability and autism

There are very few references to disability in the 10 Year Plan. We will need to look at how the needs of people with a learning disability and autistic people (as well as disabled people) are considered within the 3 shifts. In particular:

The role of **neighbourhood health teams** in providing holistic ongoing support to tackle the health inequalities experienced by disabled people, including poorer life expectancy.



Neighbourhood Health Services working in partnership with family hubs, schools, nurseries and colleges to offer **timely support to children, young people and their families** including those with Special Educational Needs and Disabilities (SEND).

Health and Work: “In the government’s Pathways to Work green paper, we further committed to developing a support guarantee, so that disabled people and those with a health condition affected by benefit changes also get the work, health and skills support they need to access and thrive in employment”

Dementia

The plan will aim to prevent people developing dementia and support the care of those currently living with the disease:

- The shift from hospital to community will make it easier for dementia patients and their carers to navigate care services by **bringing different professionals together in the Neighbourhood Health Centres**.
- The shift from analogue to digital will put the power and data in patient and carer hands. The NHS App will become a “doctor in their pocket” giving them **24/7 access to all elements of their care**, from virtual and in-person appointments, advice and guidance on symptoms, and prescription management.
- The shift from sickness to prevention will **reduce the number of people at risk of developing dementia by supporting people to live healthier lives** for longer and targeting the biggest causes of ill health.

Key policies:

- **Creating a smoke free generation by 2028** through the Tobacco and Vapes Bill. This will reduce the number of people developing dementia by addressing risk factors for dementia.
- **The My Carer tool will give family, friends and carers access to the NHS App.**

NHS operating model

- **NHS England/DHSC's** central teams will be responsible for national leadership, setting strategy, priorities and standards, allocating funding, and assessing performance.
- **NHS regions** will be responsible for performance management and oversight of providers.
- **Integrated Care Boards** will be strategic commissioners, using service commissioning and contract management to drive change.
- Provider organisations will no longer sit on ICB boards, and strategic authority mayors will replace local authority representatives on Integrated Care Boards. Integrated Care Partnerships will be abolished.
- **Neighbourhood health plans** will be drawn up by local government, the NHS and partners under the leadership of Health and Wellbeing Boards.

NHS Provider model

- The best performing Trusts will have **more autonomy** and ability to develop services.
- The **Foundation Trust model will be restored**, but will have a greater focus in partnership working and population health outcomes.
- **Providers will not be required to have governors**. Instead, providers will be expected to adopt new ways of gathering insights from patients, staff and the public, including by using patient reported outcome and experience measures.
- The best Foundation Trusts could be commissioned to spend the entire health budget for a local population by becoming an **Integrated Health Organisation (IHO).**

Workforce

- A **new 10 year workforce plan** will be published later in 2025. The new plan will aim for less workforce growth by 2035 than was included in the 2023 plan, and less than 10% international recruitment by 2035.
- Providers will be able to make **additional payments to high performing teams**.
- The NHS **Graduate Management Trainee Scheme** will be expanded by 50%.
- **New standards will be published for staff** linked to access to flexible working, healthy food, and health and wellbeing support, and protection from discrimination and abuse. Data will be published quarterly and used to inform CQC activity.
- **Agency staffing** will be eliminated by the end of this parliament.
- **Employer level data** will be published on staff employment and recruitment, broken down by **ethnicity**.
- **Diversity of trainees** enrolled in the NHS Graduate Management Trainee Scheme will be improved.

Finance

- There will be **no additional funding for deficits**. All NHS organisations will be expected to deliver plans that are compliant with the NHS planning guidance from 2026-2027. By 2029-2030, most providers will be expected to generate a surplus.
- 3-year revenue allocations and 4-year capital settlements will be introduced from 2026-2027, representing a shift towards **long-term planning**.
- All organisations will need a robust **5-year plan that demonstrates medium-term financial sustainability**, and will be expected to reserve 3% of their annual budget for service transformation.
- **Block contracts will be phased out**, and in the longer-term tariff mechanisms will be introduced which will enable funding to follow the patient through the system.
- **Patients will have the power to decide** whether providers receive the full cost of the care provided, or whether funding should be diverted to quality improvement instead.
- From 2026/27, **funding allocations** will be aligned to an area's level of **health need**.

Holistic Neighbourhood Health and Prevention

- **Neighbourhood health centres** will operate six days a week, 12 hours a day. They will be rolled out first in areas where healthy life expectancy is lowest, and will offer a range of services including debt management and employment support.
- **More money will be invested in the community** as a proportion of health spend over the next 3-4 years and more staff will be trained to deliver care in the community and primary care.
- People will be able to access **same-day GP appointments** if needed and we will see a return to **family doctors**. This will be delivered by increasing capacity in primary care – expanding the primary care workforce and reducing bureaucracy and administrative work for GPs.
- **Mandatory health food sales reporting** will be introduced for all large food companies, and this data will be used to create mandatory targets for the sale of healthy food.
- Access to weight loss medication and treatment will be expanded.

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

Darren Best, Chair

No issues to report for the period.

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 Assurance report to Board - July 25.pdf

Report to the Board of Directors
23 July 2025

Audit Committee Quarterly Assurance Report
May 2025 – July 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 risk management 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 has been one substantive meeting of the Committee during the period May 2025 – July 2025 held on 16 July. The Committee also held two extra-ordinary meetings held on 7th May and 18th June to review and approve the Trust Annual 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.

The Committee discussed the proposal to recommend to the Board an increase score in relation to risk 2511 relating to risk of not meeting regulatory and statutory requirements of Care Quality Commission registration and quality standards. The current score is 15 (a likelihood score from possible to likely). The proposal is to increase this score to 20 – likely to happen.

The committee also discussed the proposal to recommend to the Board an increase score in relation to risk 2512 relating to 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. The current score is 12 (a likelihood score from possible to likely. The proposal is to increase the score to 16 – likely to happen.

4. Issues relating to statutory and regulatory compliance and governance oversight

The Committee received an update on Patient Safety Incident Reporting Framework (PSIRF) with the purpose of the audit review was to assess progress towards successful implementation of national PSIRF standards. The audit would review progress against standards on Proportionate Responses and Engagement and Involvement on the basis standards Policy, Planning and Oversight and Competency and Capacity were established with the launch of PSIRF and have been subject to oversight and approval via the Integrated Care Board (ICB).

5. Internal audit and internal control issues and areas of focus

As of July, from the 2024/25 Internal Audit plan, eight final reports have been issued since the last committee in June 2025 and issues two final reports in relation to Cyber Assessment (CAF) Aligned Data Security and Protection Toolkit (DSPT) and the Company Data Security and Protection Toolkit (DSPT). All core and NTW Solutions Limited audits have been completed to final report.

Final 2024/25 Opinion was reported to June 25 Committee with assurance that no matters that may impact 2025/26 Opinion. Since the last committee meeting in June 2025, there has been a decrease in the number of agreed actions overdue with no update, from 13 to six.

There are two outstanding actions which are greater than 12 months overdue. Internal Audit provide assurance of their monitored performance against the Key Performance Indicators included within the Audit Charter under the Internal Audit Protocol. From 1st April 2025, they transitioned to the new K10 audit system for 2025/26 audits. KPI reporting will resume in the next progress report for the 2025/26 audit cycle as more audits are progressed.

Concerns were raised regarding the number of overdue audit recommendations and steps being taken to address these, particularly long-standing recommendations.

The Committee received the Local Counter Fraud progress report which provided strong assurance in terms of progress against the annual work plan.

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 increase the risk score in relation to risk 2511 relating to risk of not meeting regulatory and statutory requirements of Care Quality Commission registration and quality standards and also increase the risk score in relation to risk 2512 relating to 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.

Robin Earl
Chair of Audit Committee
July 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

7.2a Board - Jul -25 - Planning Paper 2025-26 v1.0.pdf

7.2b CNTW Ambitions - Aims and Priorities.pdf

Meeting	**Trust Board of Directors**		**Agenda item: 7.2**
Date of meeting	Wednesday 23rd July 2025		
Report title	2025/26 Planning – The five ambitions - aims and priorities revised		
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**
	X		
Report previously considered by	The full Trust plan has been considered by Trust Board, RABAC, Executive Management Group and Trust Leadership Forum. The five ambition objectives that this report relates to were signed off at the Trust Board in April 2025. This paper was received by EMG in June 2025		
Executive summary	Following a review, the aims and priorities for our five Trust ambitions have been refined to ensure continued relevance and impact in a rapidly evolving context. The format and design have also been strengthened. Several factors have driven this realignment including emerging system pressures, policy shifts, and learning from the first few months of the year. This adjustment ensures that our priorities remain embedded in the operational demands while retaining our strategic ambition. It strengthens our ability to deliver improvement, with greater clarity over our direction and how our ambitions are linked with our aims and priorities. **Appendix 1** on a separate pdf document shows the revised aims and priorities aligned to each of the five ambitions.		
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 2457 – Trust not considered a good partner, 2510, Risk of not meeting regulatory and statutory requirements, 2511 – Failure to embed a safe learning culture, 2512 – Failure to deliver our transformation plans around the model of care, Failure to deliver a sustainable workforce model, 2542 – Risk of poor wellbeing of staff, 2545 – Failure to deliver		

	sustainable financial position, 1687 – Managing resources effectively, 1762 – Restrictions in capital expenditure
Recommendation	The Board are asked to approve the updates to our priority areas of focus for 2025/26.
Supporting information / appendices	Not applicable

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Our five trust ambitions: aims and priorities

June 2025

With YOU in mind

Our five trust ambitions: aims and priorities

Our vision

To work together, with compassion and care, to keep you well over the whole of your life.

Our values

We are honest and transparent...

because we want to be fair and open, and to help people to make informed decisions.

We are respectful...

because everyone is of equal value, is born with equal rights and is entitled to be treated with dignity. We want to protect the rights of future generations and the planet that sustains us all.

We are caring and compassionate...

because that is how we'd want others to treat those we love

Our strategic ambitions

Quality care, every day

Person-led care, when and where it is needed

A great place to work

Sustainable for the long term, innovating every day

Working with and for our communities

Strategic ambition 1

Quality care, every day

Strategic ambition 2

Person-led care, when and where it is needed

Strategic ambition 3

A great place to work

Strategic ambition 4

Sustainable for the long term, innovating every day

Strategic ambition 5

Working with and for our communities

Strategic ambition 1

Quality care, every day

Strategic ambition 1

Quality care, every day

Quality aims

- To continue to develop and embed a positive and safe culture
- To improve physical health care
- To reduce levels of restrictive practice and violence and aggression
- To reduce levels of self-harm
- To improve the care of people with a severe and enduring mental illness

Quality priorities

- Develop a consistent and evidence-based approach to risk assessment and safety planning across all services.
- Ensure safe and coordinated transitions between services.
- Improve the early recognition and response to deteriorating patients.
- Manage and reduce the risk of severe clozapine-induced constipation.
- Continue to improve sexual safety by reducing incidents and strengthening prevention and response.
- 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 handovers of care across inpatient services.
- Improve therapeutic engagement and observation across inpatient services.
- Manage and reduce the risk of cardiorespiratory arrest caused by sedative medication.
- Support staff wellbeing through increased access to resources, compassionate leadership, and healthy workplace culture

Quality aims					Strategic ambition 1 **Quality care, every day** Quality priorities 2025/26
To continue to develop and embed a positive and safe culture	To improve physical health care	To reduce levels of restrictive practice and violence and aggression	To reduce levels of self-harm	To improve the care of people with a severe and enduring mental illness	
✓	✓	✓	✓	✓	Strengthen communication with families and carers, ensuring they are actively involved in care decisions and when a patient deteriorates
✓	✓	✓	✓	✓	Promote care planning that is person-centred, co-produced, and informed by the multidisciplinary team
✓	✓	✓	✓	✓	Develop a consistent and evidence-based approach to risk assessment and safety planning across all services
✓	✓			✓	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
✓	✓	✓	✓	✓	Improve ward handovers of care across inpatient services
✓	✓	✓	✓	✓	Improve therapeutic engagement and observation across inpatient services
	✓				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.

Strategic ambition 2

Person led care, when and where it is needed

Strategic ambition 2

Person led care, when and where it is needed

Quality aims

- Focussing on prevention and improving the front door
- Improving services for people receiving treatment in the community
- Improving services for people in the community with severe mental health needs and other complex needs
- Improving Services for people in the community with urgent needs
- Improving services for people who require additional treatment within Inpatient setting

Quality priorities

Successfully deliver and sustain the Hope Haven 24/7 Neighbourhood Health Centre as part of the government flagship Neighbourhood Health approach.

Delivery of partnership hub working across all other areas and embedding of Neighbourhood Health working.

Implementation of a new Psychosis Review and Community Clozapine Initiation Service (PRECCIS)

Develop Intensive Case Management to improve care for individuals with Severe Mental Illness.

Increase the numbers of patients accessing depot medication for SMI.

Reconfigure Inpatient services to optimise the estate to have the maximum impact on the quality and safety of patient care.

Develop, agree and progress the implementation of a new model of care for the Mitford Unit Autism Spectrum Disorder Inpatient Unit.

Reconfiguration of inpatient provision in West Cumbria.

Review of Learning Disability inpatient provision and reconfiguration.

Collaborate with TEWV, Primary Care, VCSE, and other partners to design a significantly different pathway for ADHD and Autism Spectrum Disorder needs.

Redesign and improve the pathway for specialist children and young people's eating disorder service.

Reduce waiting times for assessment and access to treatment.

Developing a strong interface between Crisis, Community, and Inpatient services to effectively meet patients' needs during a crisis, including admission pathway for UEC (community and emergency departments)

Improve UEC interface and alternatives for crisis support and intervention.

Management of frequent attenders.

Proactive support for patients who require effective discharge from inpatient care.

Quality aims					Strategic ambition 2 **Person led care, when and where it is needed**  Quality priorities 2025/26
Focussing on prevention and improving the front door	Improving services for people receiving treatment in the community	Improving services for people in the community with severe mental health needs and other complex needs	Improving Services for people in the community with urgent needs	Improving services for people who require additional treatment within Inpatient setting	
✓					• Successfully deliver and sustain the Hope Haven 24/7 Neighbourhood Health Centre as part of the government flagship Neighbourhood Health approach. • Delivery of partnership hub working across all other areas and embedding of Neighbourhood Health working.
	✓	✓			• Collaborate with TEWV, Primary Care, VCSE, and other partners to design a significantly different pathway for ADHD and Autism Spectrum Disorder needs. • Redesign and improve the pathway for specialist children and young people's eating disorder service. • Reduce waiting times for assessment and access to treatment.
		✓			• Implementation of a new Psychosis Review and Community Clozapine Initiation Service (PRECCIS) • Develop Intensive Case Management to improve care for individuals with Severe Mental Illness. • Increase the numbers of patients accessing depot medication for SMI.
✓	✓	✓	✓	✓	• Developing a strong interface between Crisis, Community, and Inpatient services to effectively meet patients' needs during a crisis, including admission pathway for UEC (community and emergency departments) • Improve UEC interface and alternatives for crisis support and intervention. • Management of frequent attenders. • Proactive support for patients who require effective discharge from inpatient care.
				✓	• Reconfigure Inpatient services to optimise the estate to have the maximum impact on the quality and safety of patient care. • Develop, agree and progress the implementation of a new model of care for the ***Mitford*** Unit Autism Spectrum Disorder Inpatient Unit. • Reconfiguration of inpatient provision in West Cumbria. • Review of Learning Disability inpatient provision and reconfiguration.

Strategic ambition 3

A great place to work

Strategic ambition 3

A great place to work

Quality aims

- Culture and leadership development
- Development of Workforce Plan
- Support the health and wellbeing of staff by providing early intervention support / reduce sickness absence

Quality priorities

- Roll out Leadership Programme (3 modules) and Clinical Support Worker Development Programme
- Map the current and future clinical support workforce requirements in line with organisational change, immigration policy changes.
- 1% sickness absence reduction across all operational and corporate areas
- Ensure that the legal framework is followed in all staff consultations and that appropriate support is put in place for staff as required
- Raise awareness across the Trust of the Sexual Safety Legislation and individual and collective responsibilities therein

Strategic ambition 3

A great place to work

Quality aims			Quality priorities 2025/26
Culture and leadership development	Development of Workforce Plan	Support the health and wellbeing of staff by providing early intervention support / reduce sickness absence	
✓			Roll out Leadership Programme (3 modules) and Clinical Support Worker Development Programme
	✓		Map the current and future clinical support workforce requirements in line with organisational change, immigration policy changes.
	✓	✓	Ensure that the legal framework is followed in all staff consultations and that appropriate support is put in place for staff as required
		✓	Raise Awareness across the Trust of the Sexual Safety Legislation and individual and collective responsibilities therein
		✓	1% sickness absence reduction across all operational and corporate areas

Strategic ambition 4

Sustainable for the long term, innovating every day

Strategic ambition 4

Sustainable for the long term, innovating every day

Quality aims

- To meet the Trust's statutory and mandated targets
- Deliver the analogue to digital shift
- Embed research into services and practice across the Trust
- Trust aim to reduce carbon emissions to 'net zero' by 2040

Quality priorities

- Deliver the Trust annual plan for 2025/26 as part of the North-East & North Cumbria ICB's financial plan to deliver financial break-even
- Develop our digital strategy to support the model of care
- Roll out paperless working in the last two remaining clinical services areas (Therapeutic Observations in Inpatients and Electronic prescriptions in the Community)
- Recognise and address the underlying financial pressure across services within the Trust and support the NHS development of Medium-Term Planning
- Green plan
- Ensure CNTW is a leader and an influencer in local and national research networks and partnerships

Strategic ambition 4

Sustainable for the long term, innovating every day

Quality aims				Quality priorities 2025/26
To meet the Trusts statutory and mandated targets	Deliver the analogue to digital shift	Embed research into services and practice across the Trust	Trust aim to reduce carbon emissions to 'net zero' by 2040	
✓				Deliver the Trust annual plan for 2025/26 as part of the North-East & North Cumbria ICB's financial plan to deliver financial break-even
✓				Recognise and address the underlying financial pressure across services within the Trust and support the NHS development of Medium-Term Planning
	✓		✓	**Develop our digital strategy to support the model of care**
	✓		✓	Roll out paperless working in the last two remaining clinical services areas (Therapeutic Observations in Inpatients and Electronic prescriptions in the Community)
		✓		Ensure CNTW is a leader and an influencer in local and national research networks and partnerships
			✓	Green Plan

Strategic ambition 5

Working with and for our communities

Strategic ambition 5

Working with and for our communities

Quality aims

- Act as a system enabler and influencer
- Drive action to reduce health inequalities

Quality priorities

- Develop an effective partnership between TEWV and CNTW and support the Provider Collaborative to be successful.
- Engage with and support the 10-year plan, transforming how services are commissioned for patients.
- Support the Neighbourhood Health Models by engaging with partners to develop new and cohesive ways of working.
- Roll out the Patient and Carer Race Equality Framework (PCREF) across all marginalised groups.

Strategic ambition 5

Working with and for our communities

Quality aims		Quality priorities 2025/26
Act as a system enabler and influencer	Drive action to reduce health inequalities	
✓	✓	Develop an effective partnership between TEWV and CNTW, and support the Provider Collaborative to be successful.
✓	✓	Support the Neighbourhood Health Models by engaging with partners to develop new and cohesive ways of working.
✓	✓	Engage with and support the 10-year plan, transforming how services are commissioned for patients.
✓	✓	Roll out the Patient and Carer Race Equality Framework (PCREF) across all marginalised groups.

Thank you

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 - July 2025.pdf

Meeting	**Board of Directors**		
Date of meeting	23 July 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 July 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 July 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. In the context of the findings, recommendations and concerns raised following recent CQC assessments across learning disabilities and autism services, community services and older people's services, a discussion took place at the Quality and Performance Committee meeting held 9 July to consider the current framing and scoring of risks relating to CQC compliance and the Trust's ability to maintain a positive patient safety learning culture. The Audit Committee reviewed the recommendation from Quality and Performance Committee to increase the risk scores in relation to risk 2511 and 2512 as follows: - 2511 – risk maintaining CQC and quality standards compliance. The proposal was to increase the score from 3 (possible) x 5 (major) = 15 to a score of 4 (likely) x 5 (major) = 20. - 2512 – risk of maintaining a positive patient safety culture. The proposal was to increase the score from 3 (possible) x 4 (significant) = 12 to a score of 4 (likely) x 4 (significant) = 16.		
Recommendation	The Trust Board are asked to **approve** the proposal to increase the risk scores for risks 2511 an 2512 detailed above.		
Supporting information	Full Board Assurance Framework is available to Board members on request.		

Board of Directors

Board Assurance Framework (BAF)/Risk Management Report
23 July 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 (April 2025 – July 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
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.	**No** **Due to other pressures, action reviews remain outstanding at the time of reporting.**	No Remains as 4 X 4 = 16	- No new controls/mitigations. - Gaps in control/actions overdue for review: • ADHD adult pathway recovery plan required with system partners. - New gaps in control/actions added: • Clinical Audit 24-037.01 Independent Seclusion Review dated 11 April 2025 - areas of concern therefore re-audit is due in Q3 25/26. - Ensure updated version of seclusion policy is circulated to all ACs/RCs within the Trust highlighting the Independent Seclusion Review guidelines within the Seclusion Policy. • Clinical Audit 24-037.01 Independent Seclusion Review dated 11 April 2025 - areas of concern therefore re-audit is due in Q3 25/26.- Focus Group to be created to discuss potential actions and put in place. Also, to review all data to identify if any areas need further help with staffing availability.
Risk 2511 Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.	Yes	Yes Current score 3 X 5 = 15 **Proposed score** 4 X 5 = 20 (increase in the likelihood score from 'possible' to 'likely')	- New controls/mitigation added - MM-24-111 Clozapine plasma levels audit dated 9 May 2025, provided a good level of assurance. - New gaps in control/actions added: • CA-24-120 Physical and Public Health dated 11 April 2025 - moderate areas of concern, high risk level, re audit due in Q3 25/26 - Create a focus group with resident doctors to discuss barriers for completion of key tasks and try to identify actions to overcome these. • CA-24-120 Physical and Public Health dated 11 April 2025 - moderate areas of concern re audit due in Q3 25/26 - Training dates to link in with

Board Assurance Framework – summary (April 2025 – July 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
			resident doctors on rotation in CNTW at induction. • MM-24-112 Monitoring during Titration of Clozapine dated 9 May 2025 - moderate areas of concern, low risk level, re audit due in Q1 2027-28 - Summary of audit results and education session about trust policy to be delivered to inpatient and community teams. Sze Yii Yap Sept 25. • MM-24-112 Monitoring during Titration of Clozapine dated 9 May 2025 - moderate areas of concern, low risk level, re audit due in Q1 2027-28 - to present audit results and findings at the Physical Health Group. • NA-23-0116: POMH 16c - Rapid Tranquillisation audit dated 9 May 2025 - moderate areas of concern, low risk level, re audit due in Q1 2026-27 - Early warning signs to be identified in a care plan. This to be reviewed and actioned by Trust wide Rapid Tranquillisation Group. • NA-23-0116: POMH 16c - Rapid Tranquillisation audit dated 9 May 2025 - moderate areas of concern, low risk level, re audit due in Q1 2026-27 - Communication of prescribing standards to medical staff. Trust wide audit of prescribing RT standards and simplified prescribing guidance within the RT policy to be developed. **Following discussion at the Quality and Performance Committee on 10 July and Audit Committee on 16 July, it is proposed that the risk**

Board Assurance Framework – summary (April 2025 – July 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
			score be increased to 4 x 5 = 20 due to the outputs and concerns raised as part of the CQC assessments in learning disabilities and autism, community services and older people's services.
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	Yes Current score 3 X 4 = 12 Proposed score 4 X 4 = 16 (increase in the likelihood score from 'possible' to 'likely')	- Additional assurance/control added – MM-24-111 Clozapine plasma levels audit dated 9 May 2025, provided a 'good' level of assurance. - New gaps in control/actions added: • MM-24-112 Monitoring during Titration of Clozapine dated 9 May 2025 - moderate areas of concern, low risk level, re audit due in Q1 2027-28 - Summary of audit results and education session about trust policy to be delivered to inpatient and community teams. Sze Yii Yap Sept 25. • MM-24-112 Monitoring during Titration of Clozapine dated 9 May 2025 - moderate areas of concern, low risk level, re audit due in Q1 2027-28 - To present audit results and findings at the Physical Health Group. • Gaps in the organisations approach to learning from incidents identified in CQC assessment reports in 2025. Similar gaps identified in Quality Peer Reviews in some areas. • CA-24-037.01 Independent Seclusion Review dated 11 April 2025 - areas of concern therefore re-audit is due in Q3 25/26 - Ensure updated version of seclusion policy is circulated to all ACs/RCs within the Trust highlighting the Independent Seclusion Review guidelines within the Seclusion Policy. • CA-24-037.01 Independent Seclusion Review dated 11 April 2025 - areas of concern, high risk level

Board Assurance Framework – summary (April 2025 – July 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
			therefore, re-audit is due in Q3 25/26 - Focus Group to be created to discuss potential actions and put in place. Also to review all data to identify if any areas need further help with staffing availability. **Following discussion at the Quality and Performance Committee on 10 July and Audit Committee on 16 July, it was proposed that the risk score be increased to 4 x 4 = 16 due to the gaps is assurance relating to the Trust's learning culture identified as part of recent CQC assessments.**
Risk 2543 Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services.	**No** **Due to other pressures, action reviews remain outstanding at the time of reporting.**	No Remains as 3 X 4 = 12	No change since previous update in April.
Risk 2542 Failure to develop a sustainable workforce model to recruit/retain/ and support the	Yes	No Remains as 4 X 4 = 16	- Additional gaps in control/actions: • At BDGR on 22nd April 2025 a deep dive was undertaken on vacancies and service delivery

Board Assurance Framework – summary (April 2025 – July 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.			linked to staffing – actions from groups required.
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	No change since previous update in April.
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	- Amended gaps in control/actions: • CNTW 2024-25 13 Outstanding Debt Resulting From Salary Sacrifice Schemes - Scoping work to take place to understand the appropriate delegation which should be put in place to allow workforce and payroll documentation to be completed.
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	No change since previous update in April.
Risk 2547 Risk that the Trust's information and systems is at higher risk of being compromised	Yes	No Remains as 3 X 4 = 12	No changes since previous update in April.

Board Assurance Framework – summary (April 2025 – July 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
leading to unknown vulnerabilities. This could lead to loss of, and/or public disclosure of, information and loss of access to critical systems.			

3. Board Committee BAF risk review summary – April 2025 – July 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.

With the exception of the proposal to increase the risk score for risks 2511 and 2512, 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 2511

The Committee discussed the proposal to recommend to the Board an increased risk score in relation to 2511 relating to compliance with CQC and quality standards. The current score is 15 (a likelihood score of 3 possible to happen). The proposal is to increase this to 4 – likely to happen. This is based on the outcome and findings of the recent CQC assessments for learning disability and autism services, community services and older people’s services.

4. Recommendation

The Board 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 increase the risk score relating to risk 2511 and 2512 as outlined in the report.

Debbie Henderson
Director of Communications, Corporate Affairs and Risk
July 2025

7.4 NTW SOLUTIONS LIMITED ? TERMS OF REFERENCE REVIEW ? FOR APPROVAL

Debbie Henderson, Director of Communications and Corporate Affairs

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REFERENCES

Only PDFs are attached

7.4 2025-07-17 Coversheet NTWS ToR.pdf

Meeting	**Board of Directors**		**Agenda item: 7.4**
Date of meeting	Wednesday 23 July 2025		
Report title	NTW Solutions Limited – Terms of Reference of Board		
Report Lead	Chris Cressey – Interim Director of Finance		
Prepared by	Sarah Jones, Director of Legal & Commercial/Company Secretary, NTWS Solutions Limited		
Purpose	**For decision**	**For assurance**	**For awareness**
	X		
Report previously considered by	Terms of Reference considered and endorsed by the Board of NTW Solutions Ltd (NTWS), June 2025		
Executive summary	The Board of NTWS have reviewed the Board's Terms of Reference and propose a few minor amendments to the document, as attached. Approval of any changes to the Terms of Reference of NTWS are a reserved matter for the Trust board under the Scheme of Reservation and Delegation of NTWS.		
Detail of corporate/ strategic risks	The fact that the Board of NTWS have reviewed the Terms of Reference, and propose amendments to improve these, provides the Trust Board with assurance that the subsidiary company is attending to its corporate governance in an appropriate manner.		
Recommendation	Approval to the amendments to the Terms of Reference of the Board of NTWS as set out in the attached document		
Supporting information / appendices	Terms of Reference of NTWS		

Board of Directors
Terms of Reference

Name	Board of Directors of NTW Solutions Limited ("the Company")
Timing & Frequency	10 board meetings will be held each year. The months when meetings will usually not take place are August and December. Meetings will normally take place on the last Tuesday of the relevant month
Support arrangements	Venue: St Nicholas Hospital, Gosforth Admin: Corporate Governance Officer Minutes: Draft within 5 working days of the meeting Papers: Circulated by end of the week prior to the meeting
Reporting arrangements	N/A
Membership	
Chair	Chair of the Board
Members	All other Non-Executive Directors Executive Managing Director Executive Director of Estates
In attendance	Company Secretary Director of Finance Corporate Governance Officer Shareholder Representative (for Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, ("the Trust")) Other company staff by invitation
Quorum	Three Directors as per the Articles of Association of the Company, with at least one director being an executive director of the Company
Deputies	None
Purpose	
The Board of Directors is collectively responsible for the exercise of powers and the performance of the company 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 to its shareholder and other stakeholders.	

The Company should be led by an effective and diverse board. The Board's role is to promote the long-term sustainability of the Company.

The Board will establish the Company's strategy, vision, and values. All directors must act with integrity, lead by example and promote the desired culture within the Company.

The Board will ensure that the necessary resources are in place for the Company to meet its objectives and its commitments to its staff, shareholder, customers and suppliers, and measure performance against these commitments.

The Board will establish a framework of prudent and effective controls that enable good governance and delegated management across the Company's business. The Board will ensure that risk is appropriately assessed and managed.

The Board should ensure that the Company's policies and practices are consistent with the Company's values and support its long-term sustainability.

The Board is responsible for ensuring that the Company has in place effective workforce planning to enable the Company to meet its commitments to its shareholder and customers.

Governance, rules and behaviours

Collective responsibility and decision making will be arbitrated by the Chair. All members of the Board have joint responsibility for every decision of the Board regardless of their individual skills or status. All directors must take decisions objectively and in the best interests of the Company and avoid conflicts of interest.

As part of their role as members of the Board, all directors have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk, risk mitigation, values, quality & standards and strategy. In particular, NEDs should scrutinise, assess and assure themselves of the performance of the Executive Directors and the Company's Leadership Team in meeting agreed goals and objectives. NEDs should ensure that they receive adequate information and monitor the Company's reporting performance, satisfying themselves as to the integrity of financial and other information and make sure that the financial controls and systems of risk management and governance are robust and implemented.

Compliance with the Company's Articles of Association, Standing Financial Instructions and these Terms of Reference will be maintained.

All members are expected to attend. Absenteeism is an exception.

Scope

The Board of Directors is responsible for:-

- Setting the Company's strategy, vision, values and standards of conduct and ensuring that its obligations to its shareholders, customers and other stakeholders are met;

- Ensuring compliance by the Company with its statutory and any regulatory requirements and contractual obligations;
- Setting the Company's strategic aims, taking into account the views of its shareholder,
- Ensuring that the necessary financial and human resources are in place to meet the Company's priorities and objectives and then periodically reviewing progress and the management of performance;
- Ensuring that the Company exercises its functions effectively, efficiently and economically.

Authority

Decision making will take place in accordance with these Terms of Reference, the Company's Articles of Association, Standing Financial Instructions and Scheme of Reservation and Delegation

Deliverables

Leadership

- Implementation and communication of a clear organisational vision, purpose and goals;
- Establishing and maintaining an effective Board and Committee structure
- Establishment and maintenance of good governance, clear lines of reporting and accountability

Strategy

- Setting and ensuring delivery of the Company's strategy
- Monitoring and reviewing performance against the strategy to ensure that its objectives are met
- Inputting into and approving the Company's annual service delivery plans

Quality

- Ensuring that internal controls are in place for delivery of quality services

Finance

- Ensuring that the Company operates effectively, efficiently and economically;
- Ensuring continued financial viability of the Company;
- Ensuring resources are properly managed and financial responsibilities are delivered
- Responsible for production, approval and publication of the Company's Annual Report and Accounts

Governance and Compliance

- Ensuring comprehensive governance arrangements are in place by complying with agreed principles, standards and systems of corporate governance;
- Formulate, implement and review the Company's Standing Financial Instructions and Scheme of Reservation and Delegation;
- Ensuring compliance with applicable legislation;
- Ensuring that the Company's Register of Interests is maintained;
- Ensuring that the Company has a comprehensive set of policies and

protocols in place that are relevant to its business, and a process of reviewing these periodically;

Risk Management

- Ensuring that there is an effective system of integrated governance, risk management and internal controls across the business operations of the Company;
- Determining and agreeing the Company's risk appetite and review this on a regular basis;
- Developing, monitoring and reviewing the Company's Board Assurance Framework and Corporate Risk Register and manage the risks to the achievement of the Company's strategy;
- Overseeing and monitoring the implementation of the Company's Risk Management Strategy and Policy

Communication and Engagement

- Developing and maintaining effective communication channels between the Board and the Company's shareholder, staff and other stakeholders;
- Ensuring effective dissemination of Company wide information on the strategy, company developments and plans.

The Shareholder Representative

For so long as it is the registered holder or beneficial owner of shares in the Company, the Trust shall be entitled to appoint one person to attend all meetings of the Directors of the Company as an observer (the Shareholder Representative) by notice in writing to the Board. Any person so appointed shall be given (at the same time as the Directors of the Company) notice of all meetings of the Directors and all agendas, written materials, minutes and other papers and/or information relating to such meetings. The Shareholder Representative shall be entitled to attend any and all such meetings and to speak and place items on the agenda for discussion provided that a Shareholder Representative shall not be entitled to vote or be counted in the quorum. The Trust may remove a Shareholder Representative and appoint another person in their place by notice in writing to the Board.

Board Committees and links to other groups

The Board of Directors may establish committees and working-groups as appropriate to carry out the business of the Board. The Board will agree terms of reference for any such committee and sub-groups and any revisions to existing terms of reference. The Terms of Reference of Board Committees will set out the powers and duties that the Board has agreed to delegate to the relevant Committee. Committees and working-groups will report to the Board.

As at the date of the adoption of these Terms of Reference the following committees of the Board are in existence:-

- **Health, Safety and Security (HSS) Committee –** a committee consisting of company executive directors, at least one NED, and with senior managers and agreed union representatives in attendance, which has responsibility for ensuring that the Company's Health and Safety policy and related procedures are adhered to and for the management of risks related to health, safety and security within the Company. The HSS Committee will provide assurance to the Board on these matters.

- **Risk Assurance & Governance (RAG) Committee** – a committee consisting of the Company's Executive Directors, at least one NED, and with senior managers in attendance, to which the Board has delegated responsibility for ensuring that there is an effective system of integrated governance, risk management and internal controls across the business operations of the Company; developing, monitoring and reviewing the Company's risk register; overseeing and monitoring the implementation of the Company's Risk Management Strategy and Policy.

  The RAG Committee will also be responsible for ensuring that the company has in place appropriate Policies and protocols across its business operations.

  The RAG Committee will monitor and manage risks related to the provision of the Company's services to its customers (including the Trust) and it will ensure that those risks are report and managed as required under its contracts with its customers.

  The RAG Committee will provide assurance to the Board on the above matters.

The Board will receive information and assurance from the Trust's audit Committee in relation to group audit matters and the Company's annual accounts and financial standing.

Date of Board approval June 2025
Date of Trust board approval [ ] 2025

Next review date: 2026

8. ANY OTHER BUSINESS / ITEMS FOR INFORMATION

Darren Best, Chair

8.1 CHAIR'S UPDATE

Darren Best, Chair

REFERENCES

Only PDFs are attached

8.1 Chairs report July Final Draft.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 8.1**
Date of meeting	Wednesday 23rd July 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 update - Annual Members / Annual General Meeting - Trust Board of Directors - Outcome Fit and Proper Persons Test - Staff Survey Results 2024 - Model Integrated Care (ICB) Blueprint - Internal and External engagement and activity - Local and Regional Network meetings		
Detail of corporate/ strategic risks	N/A		
Recommend	To note		

ation	
Supporting information / appendices	N/A

Meeting of the Board of Directors
Chair's Report
Wednesday 30th July 2025

CNTW Performance
During this reporting period CNTW has received the findings from a further CQC inspection. On this occasion the inspection was of our Community Services. Overall, the inspectors found that our services Require Improvement, (when last inspected our Community Services were rated by the CQC as Outstanding). The Trust fully accepts the CQC findings and recommendations, and I am aware that work is ongoing to cause improvements to be made. It should be noted that the CQC found much good practice and within their report there are a lot of positives that our staff should be very proud of. However, it is fair to say that the overall finding is of concern. You can read the report from 17 June 2025 assessment here.

I am proud to be the Chair of CNTW and I have absolute admiration and respect for what our people do every day. While the CQC report has highlighted areas where we must improve, it also reaffirms our commitment to delivering safe, compassionate and high-quality care. We take the findings seriously and are already working with urgency and determination to address the issues raised. Improvement is not just a goal – it is a journey we undertake together, with transparency, accountability and a shared vision for excellence.

NHS 10-year Plan
CNTW is committed to delivering high-quality, patient-cantered care in alignment with the ambitions set out in the NHS Long Term Plan (2019 – 2029). This document outlines how our strategic ambitions and service developments support the delivery of the national plan's key objectives.

1. **Preventing ill-health and supporting wellbeing.**

We are investing in proactive, community-based services that promote prevention and early intervention, in line with the Plan's focus on reducing health inequalities and supporting population health.

2. **Integrated Care and Place-Based Services**

As part of our Integrated Care System (ICS) we are working collaboratively with Primary Care, Social Care and voluntary sectors to deliver joined up care closer to home.

3. **Digitally Enabled Care**

We are embracing digital transformation to improve access, efficiency and patient experience.

4. **Workforce Development**

We are supporting our workforce through training, wellbeing initiatives and new roles to meet future service demands.

5. Financial Sustainability and Innovation

We are committed to delivering value for money while innovating to meet future challenges for example investing in green technologies to support the NHS Net Zero ambition.

As a specialist provider of mental health services, CNTW plays a vital role in delivering the ambitions of the NHS Long Term Plan. The Plan places mental health on an equal footing with physical health, committing to a significant expansion of services and funding. In response, the Trust has embedded the Plan's priorities into its strategic objectives, ensuring that care is more accessible, person-centred, and integrated across the health and care system.

One of the key areas of alignment is the expansion of community-based mental health services. The Trust is working closely with primary care networks and local partners to deliver new models of care that provide earlier intervention and support closer to home. This includes the development of integrated community mental health teams for adults with severe mental illness, as well as enhanced crisis services that offer 24/7 support. These initiatives directly support the Long Term Plan's goal of reducing reliance on inpatient care and improving outcomes through timely, localised support.

The Trust is also advancing the Plan's commitment to children and young people's mental health, with increased investment in early intervention services, school-based mental health support teams, and digital tools to improve access. In line with the Plan's focus on prevention, the Trust is embedding mental health promotion and resilience-building into its work with schools, families, and community organisations.

Furthermore, the Trust is embracing digital innovation to improve access and efficiency. Virtual consultations, online therapy platforms, and digital triage tools are being scaled up to meet rising demand and offer more flexible care options. At the same time, the Trust is investing in its workforce, developing new roles, supporting staff wellbeing, and fostering a culture of continuous improvement all of which are central to the Long Term Plan's vision for a sustainable and empowered NHS workforce.

Through these efforts, CNTW is not only delivering high-quality care but also actively contributing to the transformation of mental health services across the country, in full alignment with the national agenda.

Staff Excellence Awards 2025

Our Staff Excellence Awards took place on Friday 27th June and as Chair I was proud and delighted to acknowledge the exceptional contributions of our staff who truly make our organisation a special place to work. The awards is a testament to the exceptional dedication and achievements of individuals and teams who consistently go that extra mile delivering outstanding care for our service users and carers. The awards are a powerful tool for recognising excellence and fostering a culture of continuous improvement and I would like to thank everyone who took part in the Awards and our sponsors for their support. Let's continue to celebrate excellence and build a brighter future together.

Annual Members Meeting

I am pleased to announce our Annual Members Meeting will be held on Tuesday 23rd September 2025 in our Jubilee Theatre, St Nicholas Hospital. Before the main meeting commences at 1pm, there will be a range of stalls available from 10am with representatives

talking about the work taking place throughout the Trust and within our partner organisations and local communities.

This is an opportunity for our Trust members, service users and carers, governors, staff and members of the public to come together to learn more about our services, achievements and our vision for the future. At our meeting we will formally present our annual report and talk through some of the highlights as well as discuss work that has been undertaken over the last 12 months and our plans for the year ahead.

It is a fantastic day where I hope you can join us for a chat with our Trust and partner representatives, Council of Governors and Board of Directors about our work.

Trust Board of Directors
During June we successfully completed a recruitment process to appoint two Non-Executive Directors to the Board of Directors. The Nominations Committee has now concluded its work, and I will be seeking formal approval for the appointments at tomorrows Council of Governors meeting.

The Council of Governors extended Michael Robinson, Non-Executive Director terms of office to 30th September to provide a smooth transition and period of handover. As Michael is also the Senior Independent Director the Board of Directors have appointed Louise Nelson, Non-Executive Director into this crucial role and will consult with the Council of Governors at September meeting to formally appoint Louise as the Trusts Senior Independent Director.

Outcome Fit and Proper Persons Test
Following the revised Fit and Proper Persons Test (FPPT) published by NHS England in August 2023 the Framework introduced a requirement for the Trust Chair to submit an annual return to the NHS England Regional Director. The Framework applies to Executive and Non-Executive Directors and as Chair, I applied FFPT to all members of Board members and participants.

An NHS Leadership Competency Framework was also published which provides guidance for the competence categories against which a board member should be appointed, developed, and appraised. This Framework was effective in this round of appraisals which was used for all new board level appointments and for annual assessments for all board members.
NHS England published the first NHS Equality, Diversity and Inclusion (EDI) Improvement Plan, June 2023, which sets out targets 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. The plan centres around six high impact actions with High Impact 1 which requires the Board of Directors to have EDI objectives which are specific, measurable, relevant and timebound (SMART) and be assessed against these as part of their annual appraisal.

The appraisal for all board members undertaken by me, and the CEO completed the process. Michael Robinson, Senior Independent Director completed the review of my reports. Through the appraisal process no matters were raised that cause concerns relating to individual being fit and proper to carry out their role. All returns have been reviewed and no issues have been identified that impact on individuals' abilities to perform their duties as members of the Board. Therefore, I can determine that all board members and participants comply with the FPPT, and I have submitted the annual submission to the Regional NHS England Director.

Staf Survey Results 2024
The recent Staff Survey results for 2024 reports a mixed picture. I am concerned about the overall completion rate of our staff survey, I am of the view that the completion rate of a staff survey provides a very good insight into how engaged people are with the organisation they work for. This is something I have discussed with the CEO and asked that the completion of the 2026 staff survey is seen as one of his priorities. I want people at CNTW to have their say in the full knowledge that the survey is anonymous, that what they say matters and that the Board absolutely listens to what is said.

Whilst progress has been made in some areas, continued and renewed efforts are needed to address concerns about how we lead, how we foster a more supportive and inclusive culture and how we ensure that all our staff feel valued and empowered to speak up about issues, particularly those related to patient safety.

The culture of the organisation impacts all levels of the organisation. To address the areas specifically highlighted in 2024 survey and make a difference regarding compassion, speaking up, no bullying, continuous improvement, learning, quality, and leadership, the organisation has in place a Leadership Development Programme. The programme is aimed at Team Leaders and Managers of clinical and support teams. The programme seeks to help equip those people with the skills, tools and mindset needed to lead effectively. We know leadership is the most powerful factor influencing culture because leaders signal, through their behaviour, the values and the norms - 'the way we do things'. Leadership behaviour affects the five key elements of culture.

Cultural Elements	Values	The way we do things
Vision and values	Constant commitment to quality of care	Everyone taking responsibility in their work for living a shared vision and embodying shared values
Goals and performance	Effective, efficient, high quality performance	Everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all about performance
Support and compassion	Support, compassion and inclusion for all patients and staff	Everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action
Learning and innovation	Continuous learning, quality improvement and innovation	Everyone taking responsibility for improving quality, learning and developing better ways of doing things
Teamwork	Enthusiastic cooperation, team working and support within and across organisations	Everyone taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting

The above said, the 2024 survey does highlight some positive progress in the right direction for the Trust. These improvements demonstrate that our continued focus on improving culture, staff and patient experience is making a difference.

We must be mindful, however, that our 2024 results did not show the same rate of improvement that we have seen in the past two years. Our average % improvement per question was lower this year, we must consider this to be a critical moment in our cultural transformation.

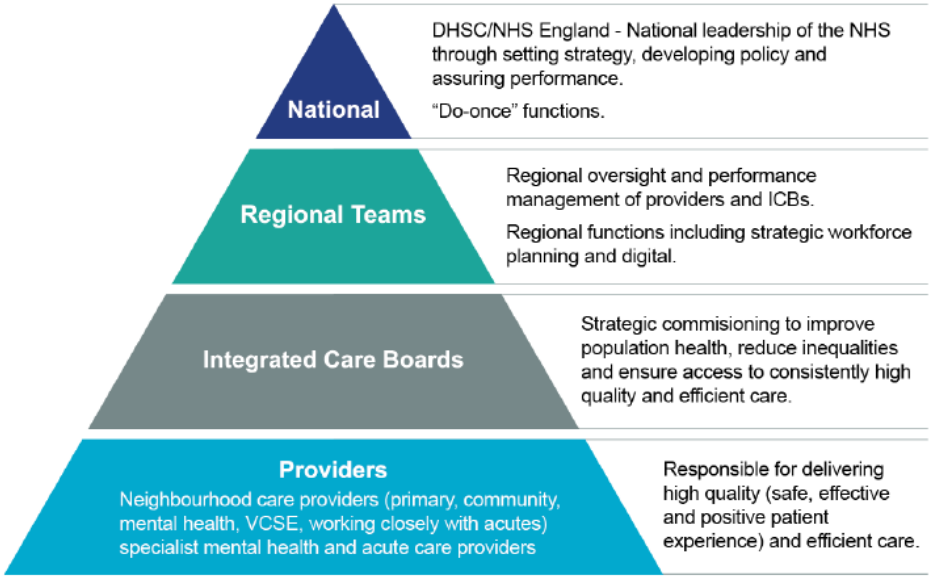
For us to continue to improve our staff morale and experience, we must be able to progress our cultural ambitions throughout 2025-26 against a tough financial backdrop. Delivering sustained and continuous improvement remains a critical challenge for the whole organisation, during a year ahead of change.

Model Integrated Care (ICB) Blueprint

In May 2025, NHS England (NHSE) shared the first version of the Model ICB Blueprint which is intended to help Integrated Care Boards (ICB) produce plans by the end of May to reduce their running costs by 50%. It sets out an initial vision for ICBs as strategic commissioners and the role they will plan in realising the ambitions of the 10 Year Health Plan. NSHE expects to carry out further engagement, including with providers to embed local plans.

The blueprint provides greater clarity on the future focus, role and functions of the ICBs. There is a greater emphasis on developing long-term strategy, establishing population health goals, and instilling collaboration within the broader NHS eco-system. This will remain a core function of their roles as commissioners within the system. To achieve this there will be a significant departure from existing operating structures, and substantial organisational transitions ahead, for the ICBs, Department of Health and Social Care and providers. The restructure presents both opportunities and challenges for ICBs as they navigate the practical implementation of these changes.

The refreshed role of the ICBs has been developed through a set of assumptions about a refreshed system landscape, along the lines set out below:



The Model ICB blueprint has significant implications for NHS Foundation Trusts, primarily involving a shift in commissioning responsibilities, increased accountability to ICBs and potential changes in governance structures. CNTW has already undertaken work to adapt our models of business to align with ICB priorities and service specifications, leading to more

streamlined service delivery. The ICB is responsible for evaluating impact and outcomes of commissioned services, potentially influencing future commissioning decisions and Trusts are held accountable to ICBs for service improvement and outcomes by demonstrating value for money and improvements in population health. The Blueprint emphasises the importance of nursing leadership at system level and CNTW will collaborate closely with the ICB to ensure clinical leadership remains a priority within the Integrated Care System (ICS).

As a Trust we align our strategic goals and priorities with the ICBs overall vision for the local health system and participate in developing and implementing the ICBs joint forward plan, which outlines how the system will meet population health needs and improve outcomes. Data sharing with the ICB will enable better understanding of population needs and health inequalities and inform service planning as well as collaborate with the ICB to commission services that meet the needs of the local population.

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 April 2025 – July 2025, I visited and / or met with:

- Service User Carer Reference Groups (April / June)
- Research and Innovation Conference
- Service visit to Lotus Ward
- Service visit to Embleton Ward
- Trust Memorial Service
- Service visit to Crisis Service, St Georges Park
- Medical Staff Committee

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
July 2025

8.2 CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

8.2 CEO Report July 25.pdf

Board of Directors
Chief Executive's Report
Wednesday 23 July 2025

1. Trust updates

1.1. Annual Staff Awards

The annual staff excellence awards were held on Friday 27 June at Newcastle Civic Centre. The awards, now in their sixteenth year continue to be extremely popular, with 1,103 nominations received this year.

Over 430 staff attended the three-course gala evening, hosted by Sky Sports presenter Pete Graves. There were 18 awards presented as well as two special awards from the Chair and Chief Executive. As last year, the awards were linked to the Trust's strategic objectives and recognised qualities such as leadership, achievement and innovation.

On the evening itself, a raffle took place raising money for the Trust's charity, and the sum of £3,325.50 was raised. In terms of sponsorship, this was the most successful year yet, with all sponsorship packages taken, including multiple prestige sponsorship packages.

1.2 Trust-wide Governance and Operational Delivery Structure Review

As part of the annual refresh of the operational governance structure a review of the Care Group Operational Management Groups (OMG) and Business Delivery Groups (BDG) has been undertaken with the aim of achieving the following:

- Establishing a formal place for learning across all care groups.
- Refocussing the monthly Care Group Quality Standards meeting.
- Improving oversight on operational performance of finance, activity and workforce standards.
- Refocussing BDG-Quality to oversee and co-ordinate the delivery of the annual quality priorities.
- Streamlining agendas where possible to free capacity.
- Move from meetings becoming solely focussed on communication cascades.
- Allowing more time for all groups to be involved in the single model of care programme board.

As a result of the above, the Executive Management Group approved changes to the Business Delivery Group meeting structure and the Care Group Operational Management Group Structure in June 2025. A report on the changes was presented to the Quality and Performance Committee in July and arrangements to support transition to the new groups has commenced.

1.3 Health Neighbourhoods

The NHS Plan sets out radical aims for the transformation of the NHS, as described in the board papers today. As part of that there is an aim for community provision to be reorganised around health neighbourhoods, in which health and care organisations across all sectors work together alongside local communities to enable us collectively to focus on the shift of care from hospital to community and to promote prevention, rather than focussing on just treating illness. This lies at the heart of the plan and to promote this NHSE are asking for 42 neighbourhoods across the country to come forward to test and develop the concept. Already discussions have been taking place across all of our localities about our approach to neighbourhood health and CNTW are a central part of all of those conversations.

A process is underway for neighbourhoods to put themselves forward as national early adopters worth bids due to be submitted in early August and successful bids to be awarded by September. Each locality is currently determining whether they will submit a proposal, but irrespective of this, momentum is building to develop the concept further locally. The national early adopters will receive coaching support and develop a network of learning but there will be no additional funding associated with this process. I will keep the board informed as this develops.

2. National updates

2.1 Planned Industrial Action by Junior Doctors – 25th July 2025

On Thursday 25th July 2025, Junior doctors in England are expected to take part in a 5 consecutive day strike as part of ongoing industrial action over pay and working conditions. This follows a series of negotiations between the British Medical Association (BMA) and the government, which have yet to reach a resolution. Junior doctors represented by the BMA are demanding full pay restoration to 2008 levels, adjusted for inflation. They argue that their real-terms pay has been cut by over 25% over the past 15 years.

The strike will involve junior doctors, who make up a significant portion of the medical workforce in hospitals and community settings. CNTW are working closely with clinical leaders to ensure patient safety remains the top priority. Emergency and urgent care services will continue to operate, but there may be disruption to non-urgent appointments and elective procedures. Patients affected by cancellations will be contacted directly and rescheduled as soon as possible. The Trust have contingency plans in place to maintain safe staffing levels, including the redeployment of senior clinicians and prioritisation of critical services. Staff are encouraged to support colleagues and patients during this period and to stay informed through internal updates and briefings.

On writing my report as the junior doctor's industrial action currently continues to go ahead, I want to take a moment to acknowledge the strength, professionalism and dedication shown by all our staff during this challenging time. We recognise that the decision to strike is never taken lightly. Junior doctors are a vital part of our workforce, and their concerns about pay, working conditions and the future of the NHS are both valid and deeply felt. Their voice matters and so does their wellbeing. We remain committed to supporting all our staff – those taking part in the industrial action and those working hard to maintain safe services. We continue to advocate for a fair and sustainable resolution that recognises the immense value

junior doctors bring to our health service. I would like to thank all our staff for your resilience, compassion and unwavering commitment to patient care. Let's continue to support one another with kindness and respect as we navigate this period together.

2.2 NHS England Attention Deficit Hyperactivity Disorder (ADHD)

In June 2025, NHS England published its interim report on the work from the ADHD (Attention Deficit Hyperactivity Disorder) national Task Force. The ADHD taskforce was commissioned by NHS England, with the support of government, after a rapid review of challenges in the health care system found that ADHD service provision and interrelated policies needed a joined-up approach across health, care, education and the justice system. The Taskforce was tasked with gaining a better understanding of the challenges affecting those with ADHD and to make recommendations for change. The taskforce has explicitly taken a whole-person, evidence-based perspective to ADHD and is focusing across health, education, employment and justice.

The report outlines a number of recommendations:

Cross-agency and government department working

1. **Data capture: government and its relevant departments (specifically DHSC, MoJ, DfE and DWP)** need to work together to improve data capture digitally and join up of datasets. This is to understand where people with ADHD or neurodivergence are in public services, the disproportionalities that exist, and to capture impacts and outcomes.
2. **The Office for National Statistics** should routinely collect and analyse data relating to ADHD in health, education, the workforce and the justice system.
3. **Spending review plans: government and its relevant departments (specifically DHSC, DfE, DWP and MoJ)** need to work together on radical and holistic spending review plans. These plans should consider the work of the Taskforce, the DWP academic panel on neurodivergence and the DfE Task and Finish group on neurodivergence. We recommend an invest to save model that includes ADHD and neurodivergence training and awareness building across all different sectors as well as evidence-based, holistic models of care (that will be described in the final report).

Prevention

4. **Needs-led support that is uncoupled from diagnosis: DHSC/NHS England, DfE and MoJ** must work together to prioritise early years support that is based on needs not diagnosis to break the school to prison, school to adult unemployment and school to ill-health pipelines. For school age children, another step is to ensure that rollout of outreach mental health support teams in schools (MHSTs; Mental Health Support Teams) is completed and enhanced by the inclusion of staff with neurodivergence expertise in every school. These teams need to be linked up with integrated neurodevelopmental and Children and Adolescent Mental Health Services (CAMHS) teams.
5. **Urgently address escalating NHS ADHD waiting times: DHSC and HMT** must act quickly to address the growing backlogs across both children's and adult services to avoid wasted expenditure on the adverse outcomes of untreated ADHD (e.g. repeated A&E use, chronic mental and physical health problems, prison, unemployment) and identify those at highest risk. The government should ensure that

local systems bring down ADHD waiting times for children's and adult services in line with its commitments on reducing waiting for diagnosis and treatment for physical health conditions.

6. **Improve support to those on waiting lists: health care providers/integrated care boards (ICBs)** must ensure support for those waiting and provide clear signposting to local organisations that can provide information and support. Health care providers/ICBs to consider screening of wait lists to identify the most severe ADHD, co-morbidities and risks (e.g. suicidal) for prioritisation using evidence-based clinical screening tools (different to profiling tools) but not on their own, as such tools can over and under-identify ADHD.

From hospital to community

7. **A generalist model:** NICE should reconsider its stance and interpretation that ADHD always requires a highly specialised, secondary care workforce (ADHD super-specialists) for diagnosis, treatment initiation, follow-up and other types of support. It should clearly define the meaning of specialist to enable greater involvement of primary care (with training and remuneration), with secondary care support as well as generalist secondary care. This approach would align ADHD management with the way other common conditions, such as diabetes, are managed. A clear definition of ADHD specialist and monitoring of NICE adherence is also important to regulate non-NHS providers and allay concerns raised by some about the quality of diagnosis or over-diagnosis by some providers.
8. **A single, accessible front door:** Integrated care systems (ICSs)/Neighbourhood Health Services need to work with other local services to modernise ADHD pathways to join up professional expertise across different types of neurodivergence/neurodevelopmental disorders. Furthermore, there needs to be an explicit link up with mental health services. Such pathways need to operate across all age groups and involve different settings of care and intensity of support (inclusive of primary and secondary care, local authority, VCSE (voluntary, community and social enterprise) and, where needed, private providers).
9. **Stepped care:** Integrated care systems (ICSs)/Neighbourhood Health Services should adopt 'test and learn approaches' to a stepped care model that involves providing support of different intensities for 'possible ADHD' and high-quality 'clinical diagnosis of ADHD'. This should involve primary and secondary care, local authority, VCSE and private providers. The NIHR should fund formal evaluation of these models.

Digitalisation

10. **Introduce NHS digitalisation into ADHD services now:** the DHSC through its 10-year plan should prioritise the digitalisation of ADHD services. Digitalisation can speed up routine administrative tasks (e.g. questionnaire measures, height, weight, blood pressure centiles, generating reports), help screen waiting lists and, where evidence based, improve efficiencies.
11. **Improve evidence base: NICE** should scope an early value assessment (EVA) of digital products delivering improved outcomes and efficiencies for ADHD management and treatment across the pathway and settings of care.
12. **Improve data quality: NHS England/DHSC** must prioritise its data improvement work. Currently, data on ADHD waiting lists, referrals, outcomes, local and regional

ADHD diagnosis and treatment rates and on clinical standards of all providers are of poor quality.

The next steps for the final report are to identify mechanisms for implementation of the interim recommendations, including holistic models of care, accountability and follow-up, continue to work with the DfE Neurodivergence Task and Finish Group and DWP Academic Panel on Neurodivergence on the final report to be completed by summer 2025.

Board members will be aware that the Trust has escalated to the Integrated Care Board (ICB) the position on the significant long waits for access to services in this pathway and the capacity the Trust has which cannot meet the growth in demand. The Trust has been working collectively with the ICB and key clinical leads to review the pathways in place across the NENC which align to the principles set out above in the interim national report.

James Duncan
Chief Executive
July 2025

8.3 FIT AND PROPER PERSONS TEST ANNUAL UPDATE (FOR INFORMATION ONLY ? PRESENTED TO JUNE CLOSED BOARD DUE TO NATIONAL SUBMISSION TIMEFRAMES)

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

8.3 FPPT DOI Report 2025 Board.pdf

Meeting	**Board of Directors**		**Agenda item: 8.3**
Date of meeting	Wednesday 23 July 2025		
Report title	Fit and Proper Person Annual Assurance Report 2024/25		
Report Lead	Debbie Henderson, Director of Communications and Corporate Affairs		
Prepared by	Kirsty Allan, Deputy Trust Secretary / Corporate Governance Manager		
Purpose	**For decision**	**For assurance**	**For awareness**
		x	
Report previously considered by			
Executive summary	The Fit and Proper Person Test (FPPT) report is an annual statutory submission to the Board as a crucial part of ensuring the board's accountability and transparency, enhancing leadership quality within the NHS and preventing unfit board members from moving between NHS organisations. The FPPT helps determine the suitability of individuals for leadership roles with the Trust, ensuring they meet the necessary standards of integrity and competency. This review helps prevent potentially harmful individuals from holding positions of influence and accountability. The report provides assurance to the Board of the individuals in director-level roles are suitable and trustworthy, safeguarding the organisation interest and those it serves.		
Detail of corporate/ strategic risks	N/A		
Recommendation	To note the outcome of the review which provides full assurance.		
Supporting information / appendices	• Appendix A - Register of FPPT outcome • Appendix B - Register of Declaration of Interests of Board member. Both appendices will be published on the Trust website to ensure transparency and demonstrate good governance. This practice promotes public confidence in the Trust by allowing scrutiny of potential conflicts of interest and helps uphold ethical standards.		

Board of Directors Meeting
Wednesday 23 July 2025

Fit and Proper Persons Annual Assurance 2024/25

1. Executive Summary

The purpose of this report is to provide annual assurance that all Board Directors, and those individuals employed for the Trust who fit the criteria of the Fit and Proper Person's national guidance, remain fit and proper for their roles.

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board Directors meet the 'Fit and Proper Persons Test.

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations in the Kark Review, NHS England developed a FPPT Framework to strengthen/reinforce individual accountability and transparency for Board members, thereby enhancing the quality of leadership within the NHS. This FPPT framework came into effect from 30 September 2023.

The Framework applies to the Board members of NHS organisations, irrespective of voting rights or contractual terms i.e. including the Director of Communications and Corporate Affairs/Company Secretary. Deputies are also included within the scope of the FPPT Framework for assurance and transparency.

Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

a) is not of good character.
b) does not have the necessary qualifications, competence, skills, and experience.
c) is not physically and mentally fit (after adjustments) to perform their duties.

These requirements play a major part in ensuring the accountability of leaders in NHS organisations and outline the requirements for robust recruitment and employment, appraisal, and performance management processes for Board level appointments and for ensuring that there are appropriate checks that leaders have the skills, knowledge and experience and integrity that they need – both when they are appointed and on an ongoing basis.

Fit and Proper Person: New Appointment and Annual Assurance Checks

All new Board appointments are subject to a full Fit and Proper Person Test that includes:

- Standard employment checks as per the Trusts Recruitment and Selection Procedure and NHS Employers Check Standards.
- Additional checks are undertaken by the Director of Communications and Corporate Affairs or deputy upon appointment / employment.

In April 2025, the Board of Directors and those people with Director in their title, completed the Fit and Proper Persons Test Self Declaration Form and additional checks as noted below in line with the new requirements of the FPPT Framework. The Register of FPPT is

included as Appendix A and will be published on the trust website for openness and transparency.

The Deputy Trust Secretary/Corporate Governance Manager has reviewed all declarations and determined that the Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

In addition, during the year 2024/25, the Executive Director of Workforce and OD has overseen the completion of pre-employment checks for new appointments and confirms that all checks meet the FPPT Framework.

Outcome of the Annual Fit and Proper Persons Checks

For annual assurance in April 2025, the Board of Directors completed the Fit and Proper Persons Self Declaration Form, checks also included:

- A search of insolvency and bankruptcy register.
- Search of Companies House register to ensure that no board member is disqualified as a director.
- Search of the Charity's Commission's Register or Removed Trustees,
- Web/Social Medial Search
- UK Civil Litigation Checks including Employment Tribunals.

Additionally, DBS checks are required to be conducted at least every three years and where practicable, these checks will be aligned to the annual self-declaration.

The outcome of the FPPTs have been saved on each personal file centrally held within the Corporate Affairs Office and uploaded onto ESR. They are then used to help inform discussions at formal appraisal processes.

Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attending of the Director of Communications and Corporate Affairs or the Trust Chair via the annual appraisal process.

Declaration of Interest

The NHS Code of Governance requires Board Directors to declare their interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties, and which could cause conflict between their private interests and their NHS duties and includes gifts and hospitality. Interests fall into the following categories:

- **Financial Interests:** Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- **Non-Financial Professional Interest:** Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making such as, increasing their professional reputation or promoting their professional career.
- **Non-Financial Personal Interests**: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect Interests:** Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

Declaration of Interests was also conducted for each Board member during April 2025 which is outlined in Appendix B and will be published on the Trust website.

Recommendations

The Board is asked to:

- Note the content of this paper and receive assurance on compliance with the Fit of Proper Persons Test for NHS Providers.
- Record that the Fit and Proper Persons Test including Declaration of Interest has been conducted for the period 2024/25 and that all Board members satisfy the requirements.
- Note that 4 Directors DBS checks are currently going through the process, once information has been received the annual submission to NHS England's Regional Director will be submitted prior to the submission date of 30 June 2025.

Debbie Henderson
Director of Communications and Corporate Affairs / Trust Secretary

Kirsty Allan
Corporate Governance Manager / Deputy Trust Secretary

April 2025

Appendix A

Fit and Proper Persons Register as at April 2025

Name & Designation	Recruitment Checks completed	DBS Check	Individual is of Good Character	Date of Last Annual Appraisal	Annual Self-Declaration Signed	Disqualified Director Register	Insolvency Service Bankruptcy Register	Charity Trustees Register	Social Media	UK Civil Litigation Check
Non-Executive Directors (NEDs)										
Darren Best, Chair	Yes	Yes	✓	28.05.2024 06.03.2025	✓	✓	✓	✓	✓	✓
Brendan Hill, Non-Executive Director	Yes	Yes	✓	29.05.2024 23.04.2025	✓	✓	✓	✓	✓	✓
Michael Robinson, Non-Executive Director	Yes	Yes	✓	29.05.2024 -	✓	✓	✓	✓	✓	✓
Louise Nelson, Non-Executive Director	Yes	Yes	✓	02.07.2024 23.04.2025	✓	✓	✓	✓	✓	✓
Vikas Kumar, Non-Executive Director	Yes	Yes	✓	02.06.2024 01.05.2025	✓	✓	✓	✓	✓	✓
Rachael Bourne, Non-Executive Director	Yes	Yes	✓	19.06.2024 29.04.2025	✓	✓	✓	✓	✓	✓
Robin Earl, Non-Executive Director	Yes	Yes	✓	08.04.2025	✓	✓	✓	✓	✓	✓
Trust Executive Directors and Board members										
James Duncan, Chief Executive	Yes	Yes	✓	17.06.2024 06.05.2025	✓	✓	✓	✓	✓	✓
Rajesh Nadkarni, Deputy Chief Executive / Medical Director	Yes	Yes	✓	11.07.2024 09.05.2025	✓	✓	✓	✓	✓	✓
Ramona Duguid, Chief Operating Officer	Yes	Yes	✓	04.06.2024 29.05.2025	✓	✓	✓	✓	✓	✓

Name & Designation	Recruitment Checks completed	DBS Check	Individual is of Good Character	Date of Last Annual Appraisal	Annual Self-Declaration Signed	Disqualified Director Register	Insolvency Service Bankruptcy Register	Charity Trustees Register	Social Media	UK Civil Litigation Check
Kevin Scollay, Executive Director of Finance	**Yes**	**Yes**	✓	**07.07.2024 08.04.2025**	✓	✓	✓	✓	✓	✓
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	**Yes**	**Yes**	✓	**22.07.2024 29.05.2025**	✓	✓	✓	✓	✓	✓
Lynne Shaw, Executive Director of Workforce and OD	**Yes**	**Yes**	✓	**27.06.2024 09.05.2025**	✓	✓	✓	✓	✓	✓
Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary	**Yes**	**Yes**	✓	**11.06.2024 08.05.2025**	✓	✓	✓	✓	✓	✓
Other staff with 'Director' in the title										
Tim Donaldson, Chief Pharmacist & Controlled Drugs Accountable Officer	**Yes**	**Yes**	✓	**- 05.02.2025**	✓	✓	✓	✓	✓	✓
Russell Patton, Deputy Chief Operating Officer	**Yes**	**Yes**	✓	**10.05.2024**	✓	✓	✓	✓	✓	✓
Julie Morrow, Deputy Director of AHP and Psychological Services	**Yes**	**Yes**	✓	**16.04.2024**	✓	✓	✓	✓	✓	✓
Emily Lennie, Deputy										

Director of AHP and Psychological Services	Yes	Yes	✓	09.02.2024	✓	✓	✓	✓	✓	✓

Name & Designation	Recruitment Checks completed	DBS Check	Individual is of Good Character	Date of Last Annual Appraisal	Annual Self-Declaration Signed	Disqualified Director Register	Insolvency Service Bankruptcy Register	Charity Trustees Register	Social Media	UK Civil Litigation Check
Esther Cohen-Tovee, Director of AHP and Psychological Services	Yes	Yes	✓	10.04.2024 16.04.2025	✓	✓	✓	✓	✓	✓
Gillian Colquhoun, Chief Information Officer	Yes	Yes	✓	- 23.04.2025	✓	✓	✓	✓	✓	✓
Lisa Strong, Deputy Director of Nursing, Therapies and Quality Assurance	Yes	Yes	✓	17.05.2024 03.06.2025	✓	✓	✓	✓	✓	✓
Simon Douglas, Director of Research	Yes	Yes	✓	- 16.04.2025	✓	✓	✓	✓	✓	✓
Claire Thomas, Deputy Director of Safer Care	Yes	Yes	✓	07.03.2024 29.05.2025	✓	✓	✓	✓	✓	✓
Terry Smith Managing Director AuditOne	Yes	Yes	✓	12.03.2024 29.04.2025	✓	✓	✓	✓	✓	✓
Andrew Buckley Non-Executive Director, NTW Solutions Limited	Yes	Yes	✓	10.07.2024 10.07.2025	✓	✓	✓	✓	✓	✓
Matthew Lessells Director of Estates, NTW Solutions Limited	Yes	Yes	✓	05.02.2025	✓	✓	✓	✓	✓	✓
Tracey Sopp Managing Director, NTW Solutions Limited	Yes	Yes	✓	04.06.2024 04.06.2025	✓	✓	✓	✓	✓	✓

Malcolm Aiston Chair, NTW Solutions	**Yes**	**Yes**	✓	**09.08.2024 08.08.2025**	✓	✓	✓	✓	✓	✓

Fit and Proper Person Test Results 2025

Please type your name and designation in BLOCK CAPITALS	Agree to Paragraph 3 of the Regulation 5 of the Regulated | Activities Regulations	The Person is an undischarged bankrupt or a person who estate has had sequestration awarded in respect of it and who has not been discharged	The person is subject of a bankruptcy restriction order	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the Children's barred list or the adults barred list maintained under Section 2 of the Safeguarding Vulnerable Groups Act 2006	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	Convicted in the UK of any offence or been convicted elsewhere of any offence	The person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals	I confirm that I MEET the Fit and Proper Persons and Good Character requirements set out above.
NON-EXECUTIVE DIRECTORS										
DARREN BEST Chair	Agree	No	No	No	No	No	No	No	No	Yes
BRENDAN HILL Non-Executive Director	Agree	No	No	No	No	No	No	No	No	Yes
ROBIN EARL Non-Executive Director	Agree	No	No	No	No	No	No	No	No	Yes
LOUISE NELSON Non-Executive Director	Agree	No	No	No	No	No	No	No	No	Yes
VIKAS KUMAR Non-Executive Director	Agree	No	No	No	No	No	No	No	No	Yes
RACHEL BOURNE Non-Executive Director	Agree	No	No	No	No	No	No	No	No	Yes
MICHAEL ROBINSON Non-Executive Director	Agree	No	No	No	No	No	No	No	No	Yes
TRUST EXECUTIVE DIRECTORS										
JAMES DUNCAN Chief Executive	Agree	No	No	No	No	No	No	No	No	Yes
RAJESH NADKARNI Deputy Chief Executive / Medical Director	Agree	No	No	No	No	No	No	No	No	Yes
RAMONA DUGUID Chief Operating Officer	Agree	No	No	No	No	No	No	No	No	Yes
KEVIN SCOLLAY Executive Director of Finance	Agree	No	No	No	No	No	No	No	No	Yes
SARAH RUSHBROOKE Executive Director of Nursing, Therapies and Quality Assurance	Agree	No	No	No	No	No	No	No	No	Yes
LYNNE SHAW Executive Director of Workforce and OD	Agree	No	No	No	No	No	No	No	No	Yes
OTHER STAFF WITH DIRECTOR IN THE TITLE										
DEBBIE HENDERSON Director of Communications and Corporate Affairs	Agree	No	No	No	No	No	No	No	No	Yes
ESTHER COHEN-TOVEE Director of AHPs &Psychological Services	Agree	No	No	No	No	No	No	No	No	Yes
JULIE MORROW Deputy Director AHP &Psychological Services	Agree	No	No	No	No	No	No	No	No	Yes
DR EMILY LENNIE Deputy Director of AHPs &Psychological Services	Agree	No	No	No	No	No	No	No	No	Yes
TIM DONALDSON Chief Pharmacist &Controlled Drugs Accountable Officer	Agree	No	No	No	No	No	No	No	No	Yes
SIMON DOUGLAS Director of Research	Agree	No	No	No	No	No	No	No	No	Yes
RUSSELL PATTON Deputy Chief Operating Officer	Agree	No	No	No	No	No	No	No	No	Yes
CLAIRE THOMAS Deputy Director Safer Care	Agree	No	No	No	No	No	No	No	No	Yes
LISA STRONG Deputy Director of Nursing, Therapies &Quality Assurance	Agree	No	No	No	No	No	No	No	No	Yes
GILLIAN COLQUHOUN Chief Digital Information Officer	Agree	No	No	No	No	No	No	No	No	Yes
MALCOLM AISTON Chair, NTW Solutions Limited	Agree	No	No	No	No	No	No	No	No	Yes
ANDREW BUCKLEY Non-Executive Director, NTW Solutions Limited	Agree	No	No	No	No	No	No	No	No	Yes
TRACEY SOPP Managing Director NTW Solutions Limited	Agree	No	No	No	No	No	No	No	No	Yes
MATTHEW LESSELLS Director of Estates	Agree	No	No	No	No	No	No	No	No	Yes
TERRY SMITH Managing Director Audit-One	Agree	No	No	No	No	No	No	No	No	Yes

Appendix B

Board of Directors Register of Interests: as at April 2025

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register of Interests which draws together Declarations of Interest made by members of the Board of Directors. In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests on items on the agenda.

NAME AND DESIGNATION	Directorships or Positions of Authority	Employment and Consultancy	Commercial Interests	Membership of any public body, organisation (voluntary or otherwise), charity or pressure group	Donations and Sponsorship	Other Interests
Non-Executive Directors (NEDs)						
Darren Best **Chair**	Wife is a Headteacher of a Primary School on Teesside, within that role she has contact with the NHS, mainly in the context of safeguarding related matters. Until standing down in April 2024, I was the Chair for the Teesside Safeguarding Adults Board.	NIL	NIL	NIL	NIL	NIL
Michael Robinson **Non-Executive Director**	NIL	NIL	NIL	Member of the Labour Party	NIL	NIL
Robin Earl **Non-Executive Director**	Sit on Finance Committee of Newcastle/Gateshead Initiative (“NGI”) in an unremunerated, Non-Executive capacity. NGI is the place marketing organisation and inward investment agency for	NIL	NIL	NIL	NIL	Brother is employed as a Consultant in Anaesthesia and Critical Care with Harrogate & District NHS Foundation Trust

	the Tyne area (and wider), and thus engages with many organisations across the region, including NHS bodies.					
Rachel Bourne **Non-Executive Director**	NIL	NIL	NIL	NIL	NIL	Brother-in-law is a Clinical Psychologist in CNTW Neuro-Rehabilitation Services.
Louise Nelson **Non-Executive Director**	Chair of Carlisle Eden Mind	NIL	NIL	Chair of Carlisle Eden Mind	NIL	NIL
Brendan Hill **Non-Executive Director**	Trustee/Non-Exec of the charity Ways to Wellness. It works in the field of health inequalities and prevention and therefore there could be potential to work with CNTW	NIL	NIL	Trustee/Non-Exec of the charity Ways to Wellness. It works in the field of health inequalities and prevention and therefore there could be potential to work with CNTW	NIL	NIL
Vikas Kumar **Non-Executive Director**	Wife is Head of Strategic Commissioning Newcastle / Gateshead ICB	NIL	NIL	CEO/Director GemArts – a charity which delivers arts, health and wellbeing programmes in collaboration with NHS	NIL	Deputy Lieutenant of Tyne and Wear
Executive Directors						
James Duncan **Chief Executive**	Non-Executive Director of Health Innovation North East and North Cumbria	Two sons employed by NTW Solutions Limited	NIL	Member of the Labour Party	NIL	NIL
Rajesh Nadkarni, Deputy Chief Executive, Medical Director	NIL	Son and Daughter employed as Bank Worker for CNTW Wife works for TEWV.	NIL	• Member of the Mental Health Economics Collaborative Steering Group, which is hosted by the Mental Health Network of NHS Confederation. • Member of the General	NIL	Medical Legal work for Courts

				Medical Council Advisory Forum. • Member of the NHS England, Health and Justice Clinical Reference Group. • Member of Integrated Care Board and Finance and Quality Sub Committees. • Member of the North East and North Cumbria Mental Health Provider Collaborative Board.		
Ramona Duguid, Chief Operating Officer	NIL	NIL	NIL	NIL	NIL	NIL
Kevin Scollay Executive Director of Finance	Partner is Head of Specialised Commissioning Finance at NHS England, who commission CNTW for specialised services	NIL	NIL	NIL	NIL	NIL
Sarah Rushbrooke Executive Director of Nursing, Therapies and Quality Assurance	NIL	NIL	NIL	NIL	NIL	NIL
Lynne Shaw, Executive Director of Workforce and OD	NIL	NIL	NIL	NIL	NIL	NIL
Debbie Henderson, Director of Communications and Corporate Affairs (Non-Voting)	Trustee, Vice Chair and Senior Independent Director for RISE North East Charity. The Chairty has links with the Trust and ICB	NIL	NIL	NIL	NIL	NIL

8.4 MODERN SLAVERY STATEMENT 2025 (FOR INFORMATION ONLY ? PRESENTED TO JUNE CLOSED BOARD DUE TO NATIONAL SUBMISSION TIMEFRAMES)

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

8.4 Modern Slavery Statement June 25.pdf

Meeting	**Board of Directors**		**Agenda item: 8.4**
Date of meeting	**Wednesday 23 July 2025**		
Report title	**Modern Slavery Statement 2024/25**		
Report Lead	**Debbie Henderson, Director of Communications and Corporate Affairs/ Trust Secretary**		
Prepared by	**Kirsty Allan, Corporate Governance Manager/Deputy Trust Secretary**		
Purpose	**For decision**	**For assurance**	**For awareness**
		x	
Report previously considered by	N/A		
Executive summary	Modern Slavery Statement is provided annually which outlines the Trusts efforts to combat modern slavery within the organisation business and supply chain, as mandated by the Modern Slavery Act 2015. We are committed to transparency and taking proactive measures to prevent and deter such practices. This report details our policies, procedures and training initiatives as well as our due diligence processes with suppliers, highlighting our ongoing commitment to modern slavery free environment. By taking these proactive measures, we aim to create a workplace and supply chain that is free from modern slavery contributes to a more just and equitable world.		
Detail of corporate/ strategic risks	N/A		
Recommendation	Board of Directors are recommended to approve and sign off the organisations modern slavery statement 2024/25.		
Supporting information / appendices	N/A		

Modern Slavery Statement

1. Introduction

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (the Trust or CNTW) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

There are many definitions of "modern slavery". Transparency International defines it as when an individual is exploited by others, for personal or commercial gain. Whether tricked, coerced or forced, they lose their freedom. This includes but is not limited to human trafficking, forced labour and debt bondage.

It involves the recruitment, movement, harbouring or receiving of children, women, or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of, or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude or even organ harvesting.

It is easy to think that modern slavery is a problem in other parts of the world and "doesn't happen here". But official figures suggest around 10,000 people in the UK are victims. Slavery experts estimate that the real number of modern slavery victims in the UK is much higher, potentially reaching 100,000 or more. In 2022, almost 17,000 potential victims of modern slavery were referred to the UKs National Referral Mechanism (NRM), representing a 33% increase on the previous year and the highest number of referrals since the NRM began in 2009.

The NHS procures a wide variety of goods and services, and some of the relevant sectors are certainly vulnerable to modern slavery. For example, there have been prosecutions in the UK in recent years relating to firms producing beds, garments, and food products – all major spend areas for many NHS Trusts.

The Trust has a zero-tolerance approach to any form of modern slavery or human trafficking. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguard against any form of modern slavery taking place within our business or supply chain.

2. About the Organisation

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest specialist providers of mental health and disability services within the UK. We employ nearly 9,000 staff and serve a local population of around 1.7 million people and have an annual turnover of around £647 million.

We work from over 70 sites across Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. We also provide a number of regional and national specialist services to England, Ireland, Scotland and Wales. Working across eight Local Authorities and a partner member of North East and North Cumbria Integrated Care System.

3. Our Commitment

CNTW condemns slavery of all forms and is fully committed to working with suppliers within our supply chain to support the human rights and welfare of the employees working alongside CNTW. We expect organisations with whom we do business to adopt and enforce policies that comply with this legislation; and would immediately seek to terminate our relationship with a supplier where evidence of a failure to comply with our policies was discovered.

CNTW is committed to ensuring that those involved within the supply chain of our business operations are working of their own free volition, in the delivery of high-quality services to all customers through a skilled and experienced workforce. CNTW will endeavour to make a conscious effort to monitor operations to ensure no individual is taken advantage of. It is the intention of CNTW to train relevant staff to recognise and report instances where the freedom of an individual is questioned.

4. Arrangements to prevent slavery and human trafficking

The Trust is committed to ensuring there is no modern slavery or human trafficking in our organisation, our supply chains, or any part of our business activity. Our approach forms a key element of our wider commitment to social and environmental responsibility and modern slavery policy also forms part of our safeguarding strategy and arrangements.

CNTW is committed to acting ethically and with integrity and transparency in all business dealing and putting effective systems and controls in place to safeguard against any form of modern slavery taking place. Yewdale ward within West Cumbria is the only mixed-sex adult acute standalone admission ward in the Trust and the decision to re-provide services from Yewdale to Carlisle will eliminate mix-sex accommodation in our hospitals. While single-sex wards in healthcare settings, like NHS hospitals, are not directly linked to modern slavery, it's important to be aware of the potential for exploitation and abuse within healthcare environments.

Our approach includes internal policies to ensure that we are conducting business in an ethical and transparent manner. They include the following:

- **Recruitment**
  CNTW complies with external policies and processes for safe recruitment and where necessary relevant employment checks will be conducted. This includes conducting eligibility to work in the UK checks for all directly employed staff. External agencies are sourced through NHS nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.

  The approach for internal recruitment follows robust processes which are in line with UK Employment Laws including ‘right to work’ document checks and contracts of employment. Our Pay structure is from national collective agreements and is based on equal pay principles.

- **Trust policies and procedures**
  All policies and procedures are developed alongside the relevant subject matter expert and signed off at an appropriate level within the Organisation.

- **Safeguarding policies**
  The Trust is committed to ensuring adherence to the principles set out with both Safeguarding Children and Young People and Safeguarding Adults policies. These provide clear guidance so that our employees are aware how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

- **Freedom to Speak up**
  We operate a Freedom to Speak Up policy and Raising Concerns (Whistleblowing) Policy so that all employees know that they can raise concerns, and how to raise concerns, about how colleagues or people receiving our services are being treated without fear of reprisals. This includes raising concerns about practices within our business or supply chain. This supports The Public Interest Disclosure Act 1998 (PIDA), which protects whistleblowers from detrimental treatment by their employer as a result of making a public interest disclosure.

- **Equal Opportunities**
  Arrangements are in placed to support raising concerns via the Freedom to Speak Up process also support good practice and protect workforce rights further. The Trust is also ensuring appropriate mechanisms to regularly review and monitor progress on promoting and supporting equality, diversity and inclusion within CNTW. To ensure equal opportunities we have a range of controls to protect staff from poor treatment or exploitation and we comply with all respective laws and regulations. This includes provision of fair pay rates, fair terms and conditions of employment and access to training and development opportunities.

5. Due Diligence

As part of our efforts to monitor and reduce the risk of slavery and human trafficking occurring within our supply chain, we have taken steps to enable us to:

- Establish and assess areas of potential risk in our business and supply chain.
- Monitor potential risk area in our business and supply chains.
- Reduce the risk of slavery and human trafficking occurring in our business and supply chains through the expectation that each entity in the supply chain, at least adopt ‘one-up’ due diligence on the next link in the chain as it is not practical for us to have a direct relationship with all links in the supply chain.
- Provide adequate protection for whistle-blowers.

Most of our purchases are against existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of contract which have the requirement for Suppliers to have suitable anti-slavery and human trafficking policies and processes to be in place.

We understand that our biggest exposure to Modern Slavery is associated with recruitment processes and recognise the importance of raising awareness within the business to identify any potential situations. Out Internal Audit plan also incorporates testing of elements of the recruitment process.

Due diligence is expected throughout the whole recruitment process and throughout the workers employment within the business. Procedures are reviewed to eliminate risk and gain compliance across all business locations.

6. Training and Awareness

All new internal employees must attend a local induction session which will provide information on the organisation, our values, policies, and procedures and include information associated with prevention of modern slavery. Existing staff will be made aware of modern slavery through local briefings planned through the year.

Our Procurement and Logistics service employ Chartered Procurement and Supply Professionals who are qualified as Fellows and Members of the Chartered Institute of Procurement and Supply who have passed the Ethical Procurement and Supply Final Test which is attached to this Professional Registration.

7. Indicators of Performance

We will gain assurance on the effectiveness of the steps that we are taking outlined in this statement, to ensure that slavery and/or human trafficking is not taking place within our business or supply chain and is committed to ensuring we always operate towards the best practices. By implementing and continually reviewing checks which minimise the risk of any form of modern slavery taking place within our operations, we can support the relevant government authorities in reporting any identified situations, and as such protect our business, our clients' businesses and first and foremost, our workers.

James Duncan
Chief Executive on behalf of the Board of Directors
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

June 2025

8.5 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

Date of next meeting
Wednesday 5th November, St Nicholas Hospital Board Room and via MS Teams